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Medicare Directory of Prevailing Charges 1979

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THE MEDICARE DIRECTORY

OF

PREVAILING CHARGES

FSY 1979

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Introduction

This directory contains Fee Screen Year 1979 Medicare reimbursement data based on physician charges submitted to Medicare during CY 1977 in each of the reasonable charge localities within each Part B carrier's service area. In addition, a separate section identifying prevailing charge screens for three items of durable medical equipment (DME) immediately follows the data for the 100 physician services.

Maps are provided for each State which outline the separate charge districts (localities) the carriers use in reimbursing claims under the Medicare program. The counties within each locality are listed to aid in identifying the exact geographic breakdowns. More detailed locality information can be obtained on selected carriers by referring to Appendix A in the back of the directory. The DME charge data is organized by Medicare regions with the appropriate data shown for each carrier.

This prevailing charge data represents the maximum amounts upon which reimbursement is based within the Medicare Part B program.* It also reflects the influence of the Economic Index Rollback Provision. For each locality, prevailing charges are listed for 30 medical services performed by General Practitioners and for 100 physician services performed by medical Specialists. Where the carrier makes no specialty differentiation in its screens, the top of the page states "combined locality designation". Blank spaces in the prevailing charge columns indicate that (a) prevailing charge data was not collected for the GP specialty category, (b) the procedure is not performed in the locality, or (c) the carrier does not use the same definition of the procedure as listed. When an asterisk (*) appears beside a charge, it means that the charge is adjusted by the application of the economic index.

When reviewing the specialist charge screen data, it should be noted that the amounts represent the prevailing charge screen for the specialist who most frequently performs these procedures. Therefore, the procedure list in Table A contains the category of medical specialists for which charge screen data was collected for the 100 procedures.

If you have any questions about the data or locality information displayed in this directory, please direct your questions to James Barnett (301-594-3846), Health Care Financing Administration, Medicare Bureau, Division of Contract Administration, Operating Policies and Procedures Section, Room 287 East Building, 6401 Security Boulevard, Baltimore, Maryland 21235.

Additional copies of the directory can be obtained from the Health Care Financing Administration, Medicare Bureau, Printing and Publications Section, Room G-M-1 East Building (Low Rise), 6401 Security Boulevard, Baltimore, Maryland 21235.

*For a more detailed discussion of the Medicare program reasonable charge methodology, the reader is directed to HCFA Publication No. 028 entitled, Determination of Reasonable Charges under Part B of Medicare.

Table A

Terminology Used in the Medicare Directory of Prevailing Charges

Due to studies of high volume medical procedures conducted in the past, only 30 of the 100 procedures will have prevailing charge screens recorded for both General Practitioners and selected Specialists. The remaining 70 procedures will have charge screens relating only to the category of specialist specified below:

<u>Procedure</u>	<u>Terminology</u>	<u>Specialist(s)</u>
1	Initial Brief Office Visit	Internist
2	Initial Limited Office Visit	GP, Internist
3	Initial Intermediate Office Visit	Internist
4	Initial Comprehensive Office Visit	GP, Internist
5	Minimal Followup Office Visit	GP, Internist
6	Brief Followup Office Visit	GP, Internist
7	Limited Followup Office Visit	GP, Internist
8	Intermediate Followup Office Visit	GP, Internist
9	Extended Followup Office Visit	GP, Internist
10	Comprehensive Followup Office Visit	GP, Internist
11	Brief Followup Home Visit	GP, Internist
12	Limited Followup Home Visit	GP, Family Practitioner
13	Intermediate Followup Home Visit	Family Practitioner
14	Extended Care Facility Visit	GP, Family Practitioner
15	Brief Followup Nursing Home Visit	Internist
16	Initial Brief Hospital Visit	GP, Internist
17	Initial Intermediate Hospital Visit	GP, Internist
18	Initial Comprehensive Hospital Visit	GP, Internist
19	Brief Followup Hospital Visit	GP, Internist
20	Limited Followup Hospital Visit	GP, Internist
21	Intermediate Followup Hospital Visit	GP, Internist
22	Extended Followup Hospital Visit	GP, Internist
23	Brief Emergency Room Visit	Internist
24	Limited Emergency Room Visit	Internist
25	Intermediate Emergency Room Visit	Internist
26	Limited Consultation	Internist
27	Extensive Consultation	GP, Internist
28	Comprehensive Consultation	Internist
29	Psychotherapy-One Hour	Internist
30	Psychotherapy-Half Hour	Psychiatrist

<u>Procedure</u>	<u>Terminology</u>	<u>Specialist(s)</u>
31	Chiropractic Office Visit	GP, Chiropractor
32	Initial Physiotherapy	Physical Therapist
33	Followup Podiatric Office Visit	Podiatrist
34	Electrocardiogram (EKG)	GP, Internist
35	EKG-Interpretation, Report Only	GP, Internist
36	Arterial Blood Gas Study	Internist
37	Electroencephalogram (EEG)	Neurologist
38	Chemotherapy	Internist 1/ Laboratory_
39	Collection of Specimens	Surgeon
40	Debridement of Nails	Surgeon
41	Skin Biopsy	Surgeon
42	Chemocautery	Surgeon
43	Radical Mastectomy	Surgeon
44	Open Reduction of Fracture	Orthopedic Surgeon
45	Arthrocentesis-Major Joint	Orthopedic Surgeon
46	Arthrotomy	GP, Orthopedic Surgeon
47	Arthroplasty	Orthopedic Surgeon
48	Needle Puncture of Bursa	Internist
49	Bronchoscopy	Internist
50	Thoracentesis	General Surgeon
51	Catherization of Heart	Cardiologist
52	Insertion of Pacemaker	Cardiologist
53	Partial Colectomy	General Surgeon
54	Appendectomy	General Surgeon
55	Sigmoidoscopy	GP, General Surgeon
56	Hemorrhoidectomy	General Surgeon
57	Cholecystectomy	General Surgeon
58	Repair Hernia	General Surgeon
59	Diagnostic Cystourethroscopy	GP, Urologist
60	Dilation of Urethra	Urologist
61	Prostatectomy	Urologist
62	Electrosection-Prostate (TUR)	GP, Urologist
63	Hysterectomy	Obstetrician-Gynecologist
64	Initial Complete Eye Exam	Opthamologist
65	Comprehensive Eye Exam	Opthamologist
66	Eye Exam with Tonometry	Opthamologist
67	Extraction of Lens	GP, Opthamologist
68	Chest X-ray-Single View	GP, Radiologist
69	Chest X-ray-Two Views	GP, Radiologist
70	X-ray-Spine	Radiologist

1/ Without regard to medical specialty or place where service was performed.

Procedure

71	X-ray-Hip	Radiologist
72	X-ray-Upper GI Tract	GP, Radiologist
73	X-ray-Colon	Radiologist
74	Radiation Therapy-Low Volt	GP, Radiologist
75	Radiation Therapy-Super Volt	GP, Radiologist
76	Radiation Therapy-Megavolt	Radiologist
77	CAT Scan-Head	Radiologist
78	CAT Scan-Head, Interpret only	Radiologist ^{1/}
79	Three Chemistry Tests	Laboratory
80	Twelve Chemistry Tests	Laboratory
81	Culture-Other than Blood	Laboratory
82	Hemoglobin	Laboratory
83	Automated Blood Count	Laboratory
84	White Cell Count	Laboratory
85	Complete Blood Count (CBC)	Laboratory
86	Cholesterol Test	Laboratory
87	Flocculation Test	Laboratory
88	Hematocrit	Laboratory
89	Platelet Count (Rees-Ecker)	Laboratory
90	Potassium Test	Laboratory
91	Prothrombin Time Test	Laboratory
92	Sedimentation Rate	Laboratory
93	Blood Sugar	Laboratory
94	BUN-Urea Nitrogen	Laboratory
95	Uric Acid	Laboratory
96	Feces-Occult Blood	Laboratory
97	Pap Test	Laboratory
98	Routine Urinalysis	Laboratory
99	Chemical Urinalysis	Laboratory
100	Pathology-Three Specimens	Laboratory

^{1/} Without regard to medical specialty or place where service was performed.

ALABAMA

[illegible]

- 01 - Seven N.W. Counties
- 02 - Six North Central Counties
- 03 - Eight S.E. Counties
- 04 - Two S.W. Counties
- 05 - One large Metropolitan County
- 06 - Forty-one small Rural Counties

2

ALABAMA

3

1979 PREVAILING CHARGE SUMMARY DATA B/C-B/S OF ALABAMA

ALABAMA

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	01	02	03	04	05	01	02	03	04	05
051 CATHETERIZATION OF HEART						59.95	351.00	425.00	346.50	425.00
052 INSERTION OF PACEMAKER						1179.00	800.00	800.00	800.00	850.00
053 PARTIAL COLECTOMY						720.00*	641.90*	784.50*	784.50*	1069.80*
054 APPENDICETOMY						305.60	335.40*	289.50*	279.60*	304.60*
055 SIG. GIDECOSCOPY	25.00*	25.00	25.00*	25.00*	25.00	35.60*	25.70*	35.00	35.60*	35.60*
056 HEMORRHOIDECTOMY						300.00*	299.50*	300.00*	300.00*	300.00
057 CHOLECYSTECTOMY						499.20*	499.20*	499.20*	535.00*	570.60*
058 REPAIR HERNIA						336.00	300.00	300.00	320.90*	356.60*
059 DIAGNOSTIC CYSTOURETHROSCOPY	70.00	60.00	71.30*	71.30*	65.00	70.00	57.10*	65.00*	71.30*	55.00
060 DILATION OF URETHRA						20.00	20.00	24.00	45.00	30.00
061 PROSTATECTOMY						700.00	641.90*	650.00	650.00	713.20*
062 ELECTROSECTOMY PROSTATE (TUR)	509.00	624.00	641.90*	608.00	744.00	570.00*	606.20*	627.60*	600.00*	650.00
063 HYSTERECTOMY						600.00	600.00	600.00	600.00	600.00
064 INITIAL COMPLETE EYE EXAM						19.90	16.00	15.00	20.00	20.00
065 COMPREHENSIVE EYE EXAM						25.00	17.00	25.00	26.60*	30.00
066 EYE EXAM WITH TONOMETRY						12.00	10.70*	12.00	12.00	10.00
067 EXTRACTION OF LENS	603.00	624.00	672.00	950.00	744.00	600.00	600.00	650.00	641.90*	713.20*
068 CHEST X-RAY, SINGLE VIEW	17.90*	20.00	17.10*	21.40*	20.00	15.00*	15.00	17.00*	18.60*	20.00
069 CHEST X-RAY, TWO VIEWS	201.00	21.40*	20.00	21.40*	23.00	20.00	21.40*	24.30*	21.40*	21.40*
070 X-RAY SPINE						32.00	32.00	32.00*	32.00	35.00
071 X-RAY HIP						25.00	25.00	25.00	25.00*	26.00
072 X-RAY UPPER GI TRACT	49.90*	49.90*	50.00*	49.90*	49.90*	50.00	57.19*	52.00	55.00	49.00
073 X-RAY COLON						45.00	49.90*	55.00	49.90*	49.00
074 RADIATION THERAPY-LOW VOLT	15.00	15.00	15.00	15.00	15.00	20.00	20.00	19.90*	15.70*	15.70*
075 RADIATION THERAPY-SUPER VOLT	21.00	21.00	21.00	21.00	21.00	21.00	29.70*	24.10*	26.20*	26.20*
076 RADIATION THERAPY-MEGAVOLT						32.00	32.00	28.60*	32.00	33.40*
077 CAT SCAN - HEAD						300.00	300.00	300.00	300.00	300.00
078 CAT SCAN-HEAD, INTERPRET ONLY						37.50	37.50	37.50	37.50	37.50
079 THREE CHEMISTRY TESTS						10.50	10.50	10.50	10.50	10.50
080 TWELVE CHEMISTRY TESTS						12.60	12.60	12.60	12.60	12.60
081 CULTURE-OTHER THAN BLOOD						10.00	18.00	12.50	8.60	15.00
082 HEMOGLOBIN						4.00	4.00	3.00	3.44	4.00
083 AUTOMATED BLOOD COUNT						5.70	5.04	7.50	5.16	4.98
084 WHITE CELL COUNT						4.00	5.00	6.00	3.44	5.00
085 COMPLETE BLOOD COUNT (CBC)						10.00	10.00	8.00	10.32	10.00
086 CHOLESTEROL TEST						9.00	7.00	8.00	8.60	8.00
087 FLOCCULATION TEST						7.00	5.04	6.00	5.16	6.00
088 HEVATOCRIT						5.00	4.00	5.00	3.44	5.00
089 PLATELET COUNT (REES-ECKER)						9.00	7.00	6.00	3.44	8.00
090 POTASSIUM TEST						8.00	8.00	8.00	8.60	9.00
091 PROTHROMBIN						7.00	8.00	6.00	6.02	8.00
092 SEDIMENTATION RATE						5.00	8.00	6.00	5.16	6.00
093 BLOOD SUGAR						10.00	8.00	9.00	8.60	10.00
094 BUN-UREA,NITROGEN						8.00	7.00	8.00	8.60	8.50
095 URIC ACID						8.00	8.40	8.00	8.60	8.00
096 FECES-OCULT BLOOD						5.00	1.68	3.00	1.72	5.00
097 PAP TEST						12.00	10.00	10.00	8.60	10.00
098 ROUTINE URINALYSIS						5.00	7.00	7.00	4.30	7.00
099 CHEMICAL URINALYSIS						2.85	2.52	2.55	2.58	2.49
100 PATHOLOGY-THREE SPECIMENS						30.00	20.00	22.00	2.58	20.00

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

1979 PREVAILING CHARGE SUMMARY DATA B/C-B/S OF ALABAMA

ALABAMA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

06

06

001	INITIAL BRIEF OFFICE VISIT			001
002	INITIAL LIMITED OFFICE VISIT			002
003	INIT INTERMED OFFICE VISIT			003
004	INIT COMP OFFICE VISIT	25.00	49.90*	004
005	MINIMAL F/U OFFICE VISIT			005
006	BRIEF F/U OFFICE VISIT	12.00	12.00	006
007	LIMITED F/U OFFICE VISIT			007
008	INTERMED F/U OFFICE VISIT	15.00	16.00	008
009	EXTENDED F/U OFFICE VISIT			009
010	COMPLETE F/U OFFICE VISIT	25.00	45.00	010
011	BRIEF F/U HOME VISIT	15.00	14.30*	011
012	LIMITED F/U HOME VISIT			012
013	INTERMEDIATE F/U HOME VISIT			013
014	EXTENDED CARE FACILITY VISIT			014
015	BRIEF F/U NURSING HOME VISIT	15.00	15.00	015
016	INITIAL BRIEF HOSPITAL VISIT			016
017	INIT INTERMED HOSPITAL VISIT			017
018	INITIAL COMP HOSPITAL VISIT	40.00	49.90*	018
019	BRIEF F/U HOSPITAL VISIT	10.00	10.00	019
020	LIMITED F/U HOSPITAL VISIT	7.50	12.50	020
021	INTERMED F/U HOSPITAL VISIT			021
022	EXTENDED F/U HOSPITAL VISIT			022
023	BRIEF EMERGENCY ROOM VISIT			023
024	LIMITED EMERGENCY ROOM VISIT			024
025	INTERMED EMERGENCY ROOM VISIT	30.00	20.00	025
026	LIMITED CONSULTATION			026
027	EXTENSIVE CONSULTATION		35.00	027
028	COMPREHENSIVE CONSULTATION		57.10*	028
029	PSYCHOTHERAPY-ONE HOUR			029
030	PSYCHOTHERAPY-HALF HOUR		49.90*	030
031	CHIROPRACTIC OFFICE VISIT		21.40*	031
032	INITIAL PHYSIOTHERAPY		8.00	032
033	F/U PODIATRIC OFFICE VISIT		8.30	033
034	ELECTROCARDIOGRAM (EKG)			034
035	EKG-INTERPRET-REPORT ONLY	21.40*	23.00	035
036	ARTERIAL BLOOD GAS STUDY	15.00	15.00	036
037	ELECTROENCEPHALOGRAPH (EEG)			037
038	CHEMOTHERAPY			038
039	COLLECTION OF SPECIMENS		38.75	039
040	DEBRIDEMENT OF NAILS		16.00	040
041	SKIN BIOPSY		2.00	041
042	CHEMOCAUTERY		35.60*	042
043	RADICAL MASTECTOMY		35.00	043
044	OPEN REDUCTION OF FRACTURE		58.80	044
045	ARTHROCENTESIS-MAJOR JOINT		747.60*	045
046	ARTHROTOMY		445.50	046
047	ARTHROPLASTY-REPAIR OF HIP	25.00	20.00	047
048	NEEDLE PUNCTURE OF BURSA		19.80	048
049	BRONCHOSCOPY		1237.50	049
050	THORACENTESIS		19.60	050
			150.00*	
			75.00*	

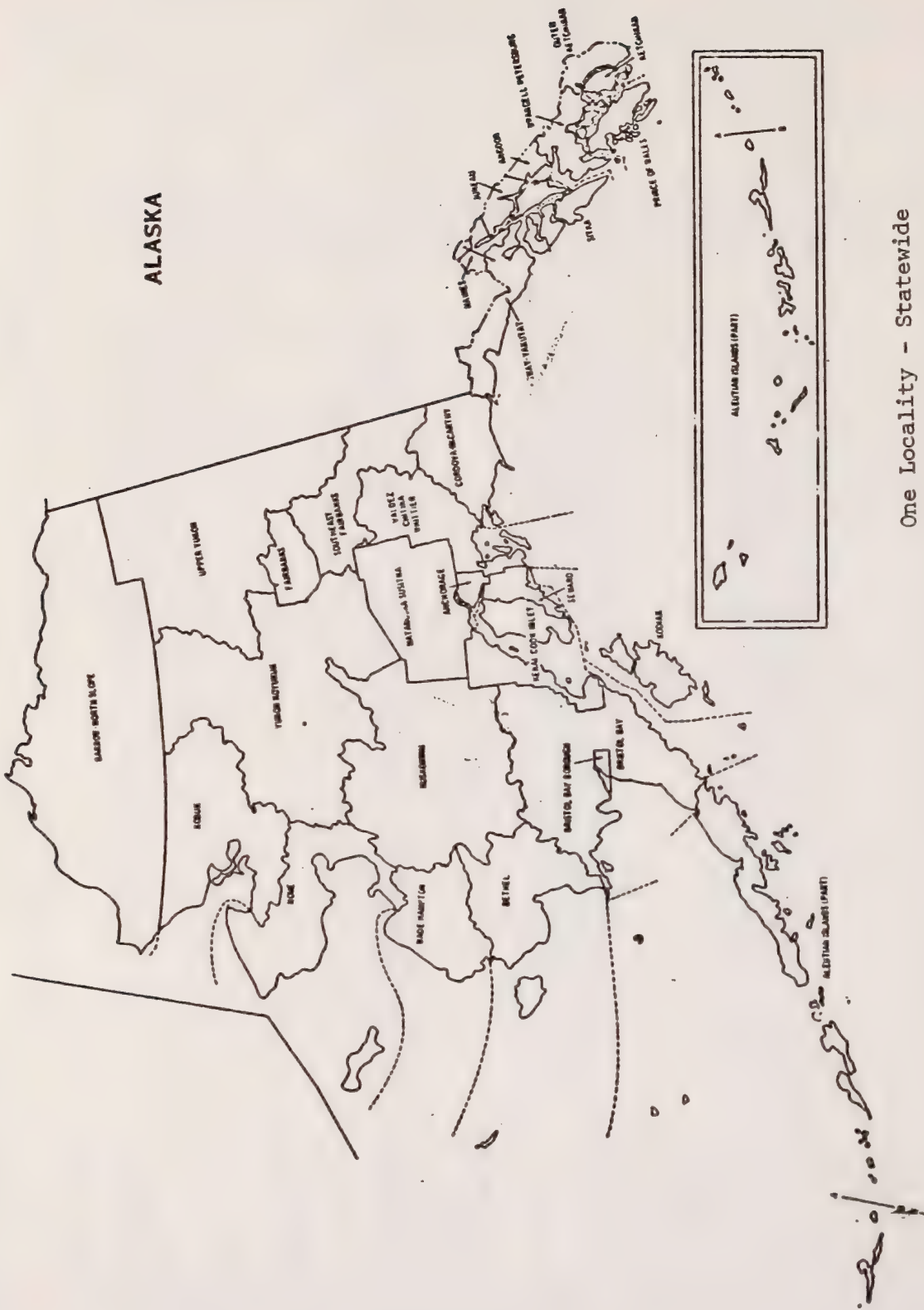
1979 PREVAILING CHARGE SUMMARY DATA B/C-B/S OF ALABAMA

ALABAMA

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE	LOCALITY DESIGNATION FOR SPECIALIST
	06	06
051 CATHETERIZATION OF HEART		405.00 051
052 INSERTION OF PACEMAKER		810.00 052
053 PARTIAL COLECTOMY		675.00 053
054 APPENDECTOMY		333.10* 054
055 SIGMOIDOSCOPY	25.00	35.60 055
056 HEMORRHOIDECTOMY		300.00 056
057 CHOLECYSTECTOMY		57.10 057
058 REPAIR HERNIA		300.00 058
059 DIAGNOSTIC CYSTOURETHROSCOPY	71.30*	57.10 059
060 DILATION OF URETHRA		15.00 060
061 PROSTATECTOMY		700.00 061
062 ELECTROSECTION-PROSTATE (TUR)	608.00	641.90 062
063 HYSTERECTOMY		600.00 063
064 INITIAL COMPLETE EYE EXAM		20.00 064
065 COMPREHENSIVE EYE EXAM		29.90 065
066 EYE EXAM WITH TONOMETRY	608.00	15.00 066
067 EXTRACTION OF LENS	17.10*	650.00 067
068 CHEST X-RAY, SINGLE VIEW	21.40*	16.00 068
069 CHEST X-RAY, TWO VIEWS		20.00 069
070 X-RAY SPINE		32.00 070
071 X-RAY HIP		25.00 071
072 X-RAY UPPER GI TRACT	45.00	55.00 072
073 X-RAY COLON		49.90* 073
074 RADIATION THERAPY-LOW VOLT	15.00	15.00 074
075 RADIATION THERAPY-SUPER VOLT	21.00	21.00 075
076 RADIATION THERAPY-MEGAVOLT		30.00 076
077 CAT SCAN - HEAD		300.00 077
078 CAT SCAN-HEAD, INTERPRET ONLY		37.50 078
079 THREE CHEMISTRY TESTS		10.50 079
080 TWELVE CHEMISTRY TESTS		12.60 080
081 CULTURE-OTHER THAN BLOOD		8.60 081
082 HEMOGLOBIN		3.44 082
083 AUTOMATED BLOOD COUNT		5.16 083
084 WHITE CELL COUNT		3.44 084
085 COMPLETE BLOOD COUNT (CBC)		10.32 085
086 CHOLESTEROL TEST		8.60 086
087 FLOCCULATION TEST		5.16 087
088 HEWATOCRIT		3.44 088
089 PLATELET COUNT (REES-ECKER)		3.44 089
090 POTASSIUM TEST		8.60 090
091 PROTHROMBIN		6.02 091
092 SEDIMENTATION RATE		5.16 092
093 BLOOD SUGAR		8.60 093
094 BUN-UREA, NITROGEN		8.60 094
095 URIC ACID		8.60 095
096 FECES-OCCULT BLOOD		1.72 096
097 PAP TEST		8.60 097
098 ROUTINE URINALYSIS		4.30 098
099 CHEMICAL URINALYSIS		2.58 099
100 PATHOLOGY-THREE SPECIMENS		2.58 100

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

ALASKA



One Locality - Statewide

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

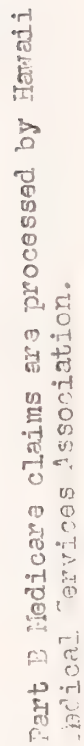
PROCEDURE DESCRIPTION	SINGLE	SINGLE
001 INITIAL BRIEF OFFICE VISIT	28.50*	22.80*
002 INITIAL LIMITED OFFICE VISIT		35.60*
003 INIT INTERMED OFFICE VISIT		63.80*
004 INIT COMP OFFICE VISIT	71.40*	71.40*
005 MINIMAL F/U OFFICE VISIT	11.40*	12.20*
006 BRIEF F/U OFFICE VISIT	17.10*	17.10*
007 LIMITED F/U OFFICE VISIT	21.30*	22.80*
008 INTERMED F/U OFFICE VISIT	22.00*	28.50*
009 EXTENDED F/U OFFICE VISIT	42.80*	42.80*
010 COMPLETE F/U OFFICE VISIT	54.20*	68.00
011 BRIEF F/U HOME VISIT	28.50*	28.50*
012 LIMITED F/U HOME VISIT		42.80*
013 INTERMEDIATE F/U HOME VISIT	37.20*	42.80*
014 EXTENDED CARE FACILITY VISIT		15.50
015 BRIEF F/U NURSING HOME VISIT	14.30*	14.20*
016 INITIAL BRIEF HOSPITAL VISIT	42.80*	42.80*
017 INIT INTERMED HOSPITAL VISIT		71.40*
018 INITIAL COMP HOSPITAL VISIT	71.40*	71.40*
019 BRIEF F/U HOSPITAL VISIT	17.10*	17.10*
020 LIMITED F/U HOSPITAL VISIT	30.00	33.00
021 INTERMED F/U HOSPITAL VISIT	38.50*	40.90*
022 EXTENDED F/U HOSPITAL VISIT		49.30*
023 BRIEF EMERGENCY ROOM VISIT		28.20*
024 LIMITED EMERGENCY ROOM VISIT		36.00*
025 INTERMED EMERGENCY ROOM VISIT		65.70*
026 LIMITED CONSULTATION	36.80*	39.00*
027 EXTENSIVE CONSULTATION		66.70*
028 COMPREHENSIVE CONSULTATION		71.40*
029 PSYCHOTHERAPY-ONE HOUR		42.80*
030 PSYCHOTHERAPY-HALF HOUR		19.20*
031 CHIROPRACTIC OFFICE VISIT	15.00	12.50*
032 INITIAL PHYSIOTHERAPY		17.28
033 F/U PODIATRIC OFFICE VISIT		14.00*
034 ELECTROCARDIOGRAM (EKG)	42.80*	36.40*
035 EKG-INTERPRET, REPORT ONLY	12.00	16.00
036 ARTERIAL BLOOD GAS STUDY		108.50
037 ELECTROENCEPHALOGRAPH (EEG)		94.50
038 CHEMOTHERAPY		20.60*
039 COLLECTION OF SPECIMENS		3.00
040 DEBRIDEMENT OF NAILS		25.40
041 SKIN BIOPSY		36.00
042 CHEMOCAUTERY		20.30*
043 RADICAL MASTECTOMY		889.00
044 OPEN REDUCTION OF FRACTURE		1254.90*
045 ARTHROCENTESIS-MAJOR JOINT		35.60*
046 ARTHROTOMY		30.00*
047 ARTHROPLASTY-REPAIR OF HIP		1537.50
048 NEEDLE PUNCTURE OF BURSA		30.00*
049 BRONCHOSCOPY		183.00*
050 THORACENTESIS		45.70*

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

SINGLE

SINGLE

PROCEDURE DESCRIPTION	SINGLE	SINGLE	
051 CATHETERIZATION OF HEART		499.50	051
052 INSERTION OF PACEMAKER		774.30*	052
053 PARTIAL COLECTOMY		1116.00	053
054 APPENDECTOMY		530.40*	054
055 SIGMOIDOSCOPY	36.50	39.00	055
056 HEMORRHOIDECTOMY		381.00	056
057 CHOLECYSTECTOMY		827.10*	057
058 REPAIR HERNIA		577.50*	058
059 DIAGNOSTIC CYSTOURETHROSCOPY	66.30*	84.00	059
060 DILATION OF URETHRA		21.30*	060
061 PROSTATECTOMY		944.00	061
062 ELECTROSECTION-PROSTATE (TUR)	1060.90*	1026.60*	062
063 HYSTERECTOMY		805.00	063
064 INITIAL COMPLETE EYE EXAM		34.20*	064
065 COMPREHENSIVE EYE EXAM		54.00	065
066 EYE EXAM WITH TONOMETRY		15.00	066
067 EXTRACTION OF LENS	1060.90*	1140.75*	067
068 CHEST X-RAY, SINGLE VIEW	24.00	22.80*	068
069 CHEST X-RAY, TWO VIEWS	35.60*	34.20*	069
070 X-RAY SPINE		45.00	070
071 X-RAY HIP		42.80*	071
072 X-RAY UPPER GI TRACT	79.90*	68.50*	072
073 X-RAY COLON		62.00*	073
074 RADIATION THERAPY-LOW VOLT	36.60	34.50	074
075 RADIATION THERAPY-SUPER VOLT	48.80	46.00	075
076 RADIATION THERAPY-MEGAVOLT		46.00	076
077 CAT SCAN - HEAD			077
078 CAT SCAN-HEAD, INTERPRET ONLY		23.80	078
079 THREE CHEMISTRY TESTS		49.00	079
080 TWELVE CHEMISTRY TESTS		14.00	080
081 CULTURE-OTHER THAN BLOOD		5.60	081
082 HEMOGLOBIN		12.50	082
083 AUTOMATED BLOOD COUNT		5.60	083
084 WHITE CELL COUNT		16.00	084
085 COMPLETE BLOOD COUNT (CBC)		15.50	085
086 CHOLESTEROL TEST		8.00	086
087 FLOCCULATION TEST		5.60	087
088 HEMATOCRIT		12.00	088
089 PLATELET COUNT (REES-ECKER)		14.00	089
090 POTASSIUM TEST		10.90	090
091 PROTHROMBIN		9.00	091
092 SEDIMENTATION RATE		13.60	092
093 BLOOD SUGAR		14.00	093
094 BUN-UREA, NITROGEN		14.00	094
095 URIC ACID		14.00	095
096 FECES-OCULT BLOOD		2.80	096
097 PAP TEST		12.50	097
098 ROUTINE URINALYSIS		8.00	098
099 CHEMICAL URINALYSIS		4.20	099
100 PATHOLOGY-THREE SPECIMENS		43.50	100

[illegible]

Map of Arizona showing county boundaries and names. Six localities are circled and numbered:

- 01 - Phoenix
- 02 - Tucson
- 05 - Flagstaff
- 07 - Prescott
- 08 - Yuma
- 99 - Santa Cruz

01 - Phoenix

01 - Phoenix

02 - Tucson
05 - Flagstaff

05 - Flagstaff

07 - Prescott

08 - Yuma

99 - All other parts of the State

(For more locality information see Appendix A)

1979 PREVAILING CHARGE SUMMARY DATA

ARIZONA

AETNA LIFE AND CASUALTY

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	07	08	05	01	02	07	08	05
001 INITIAL BRIEF OFFICE VISIT	35.60*	35.60*	35.60*	25.00	30.00	25.00	28.50*	21.30*	23.10*	23.10*
002 INITIAL LIMITED OFFICE VISIT						50.00	35.00	40.00*	40.00*	30.00*
003 INIT INTERMED OFFICE VISIT						21.30*	21.30*			
004 INIT COMP OFFICE VISIT	49.90*	40.00	40.00*	50.00	40.00*	64.10*	55.00	53.10*	53.10*	53.10*
005 MINIMAL F/U OFFICE VISIT	7.20*	8.00*	5.70*	2.90*	6.00*	8.60*	7.20*	7.20*	6.00*	6.00*
006 BRIEF F/U OFFICE VISIT	11.40*	11.40*	11.40*	10.70*	10.00*	17.10*	14.30*	11.80*	11.80*	11.60*
007 LIMITED F/U OFFICE VISIT	14.30*	14.30*	21.30*	12.00	11.00	18.00	17.00	15.00*	17.00	16.00
008 INTERMED F/U OFFICE VISIT	20.00	15.00	15.00	15.00	15.00	21.30*	18.00	20.00	20.00	20.00
009 EXTENDED F/U OFFICE VISIT	30.00	25.00	25.00*	25.00*	30.00	30.00	40.00	30.00	30.00	30.00
010 COMPLETE F/U OFFICE VISIT	45.60*	26.50	35.00*	42.80*	43.30*	49.90*	37.00	49.90*		40.00*
011 BRIEF F/U HOME VISIT	21.30*	21.30*	21.30*	21.30*	21.30*	21.30*	21.30*			
012 LIMITED F/U HOME VISIT						35.00	25.00			
013 INTERMEDIATE F/U HOME VISIT	25.00	30.00	29.50*	30.00		35.00	25.00			
014 EXTENDED CARE FACILITY VISIT						20.00	23.20*			
015 BRIEF F/U NURSING HOME VISIT	11.40*	11.40*	11.40*	10.70*		17.10*	14.30*	11.80*	11.80*	
016 INITIAL BRIEF HOSPITAL VISIT	35.60*	42.80*	30.00*	45.00	42.80*	49.90*	42.80*	40.00*	40.00*	45.00*
017 INIT INTERMED HOSPITAL VISIT						49.90*	42.80*	55.00	49.90*	55.00
018 INITIAL COMP HOSPITAL VISIT	49.90*	51.30*	28.50*	64.10*	45.00*	70.00	49.90*	64.10*	57.00*	50.00
019 BRIEF F/U HOSPITAL VISIT	14.30*	14.30*	11.40*	12.50	14.30*	17.10*	14.30*	14.20*	14.20*	15.00*
020 LIMITED F/U HOSPITAL VISIT	20.00	15.00	15.00	20.00	18.00	21.30*	19.00	17.10*	20.00	18.00
021 INTERMED F/U HOSPITAL VISIT	20.00	15.00	12.30*	15.00		21.30*	15.00	13.80*	13.80*	14.30*
022 EXTENDED F/U HOSPITAL VISIT						30.00	30.00	30.00	30.00	
023 BRIEF EMERGENCY ROOM VISIT						25.00	25.00			
024 LIMITED EMERGENCY ROOM VISIT						38.00	35.00			
025 INTERMED EMERGENCY ROOM VISIT	36.40*	39.80*	39.70*	39.70*	39.70*	60.00	60.00	37.60*		35.00*
026 LIMITED CONSULTATION						39.60*	50.00	36.60*	35.10*	55.20*
027 EXTENSIVE CONSULTATION						57.50*	50.00	55.00	55.00	55.00
028 COMPREHENSIVE CONSULTATION						71.40*	59.90*	64.10*	56.00*	64.10*
029 PSYCHOTHERAPY-ONE HOUR						41.30*	29.80*	48.90*	48.90*	48.90*
030 PSYCHOTHERAPY-HALF HOUR						27.50*	17.90*	29.30*	29.30*	29.30*
031 CHIROPRACTIC OFFICE VISIT	12.20*	14.00	12.20*	12.20*	14.70*	12.00	12.00	10.00	10.00	10.00
032 INITIAL PHYSIOTHERAPY						15.00*	15.00*			
033 F/U PODIATRIC OFFICE VISIT						14.30*	14.30*	14.30*	10.00*	11.60*
034 ELECTROCARDIOGRAM (EKG)	25.00*	24.30*	25.00	21.30*	20.00	25.00	21.30*	25.00	25.00	20.00
035 EKG-INTERPRET-REPORT ONLY	6.00	6.00				9.00	9.00		7.30*	
036 ARTERIAL BLOOD GAS STUDY						35.00	79.80		71.40*	
037 ELECTROENCEPHALOGRAM (EEG)						65.00	60.00		12.20*	15.00
038 CHEMOTHERAPY						15.00	10.00		3.00	
039 COLLECTION OF SPECIMENS						3.00	3.00		3.00	
040 DEBRIDEMENT OF NAILS						15.00	15.00		12.50*	
041 SKIN BIOPSY						33.00	35.00		29.25*	
042 CHEMOCAUTERY						18.00	20.00		20.00	
043 RADICAL MASTECTOMY						799.60*	713.00		678.80*	658.00
044 OPEN REDUCTION OF FRACTURE						941.20*	798.60*		946.60*	713.30*
045 ARTHROCENTESIS-MAJOR JOINT						28.50*	29.10*		28.50*	33.60
046 ARTHROTOMY						21.30*	21.30*		21.30*	22.10*
047 ARTHROPLASTY-REPAIR OF HIP						1400.00	1337.50		1462.50	1400.00
048 NEEDLE PUNCTURE OF BURSA	21.00	22.00	15.00	28.50*	19.40*	30.00*	19.40*		30.00*	18.80
049 BRONCHOSCOPY						150.00*	159.00		171.10*	141.00
050 THORACENTESIS						30.00	30.00		25.10*	28.20

1979 PREVAILING CHARGE SUMMARY DATA

ARIZONA

AETNA LIFE AND CASUALTY

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	07	08	05	01	02	07	08	05
051 CATHETERIZATION OF HEART						450.00	500.00*			477.00
052 INSERTION OF PACEMAKER						1069.50*	805.40*			1060.00
053 PARTIAL COLECTOMY						912.60*	855.60*		775.70*	912.60*
054 APPENDECTOMY						456.30*	475.60*	912.60*	417.90*	401.70*
055 SIGMOIDOSCOPY	30.00	35.00	42.80*	27.90*	25.70*	32.00	28.50*	28.50*	25.00*	25.70*
056 HEMORRHOIDECTOMY						356.50*	325.10*	332.30*		289.25*
057 CHOLECYSTECTOMY						677.40*	598.90*	581.80*	581.80*	513.40*
058 REPAIR HERNIA						399.30*	370.80*	339.40*	339.40*	328.00*
059 DIAGNOSTIC CYSTOURETHROSCOPY	48.60*	45.00		44.20*		49.90*	50.00	49.90*	48.60	49.90*
060 DILATION OF URETHRA						21.30*	17.10*	21.30*	15.00*	21.30*
061 PROSTATECTOMY						798.60*	741.40*	755.70*	718.60*	
062 ELECTROSECTION-PROSTATE (TUR)	596.00	798.60*				798.60*	741.40*	784.30*	775.70*	784.30*
063 HYSTERECTOMY						713.00*	713.00*	621.00*	622.80*	
064 INITIAL COMPLETE EYE EXAM						28.00	25.60	28.00	22.80*	
065 COMPREHENSIVE EYE EXAM						27.50*	24.60*		24.60*	
066 EYE EXAM WITH TONOMETRY						14.30*	12.00	13.80*	11.60*	
067 EXTRACTION OF LENS	696.00	720.00				713.00*	713.00*	713.00*	713.00*	713.00*
068 CHEST X-RAY, SINGLE VIEW	20.00	16.00	21.00	15.70*	20.00	20.00	17.10*		17.50*	17.10*
069 CHEST X-RAY, TWO VIEWS	25.70*	25.70*	22.80*	21.00*	25.70*	23.90*	25.70*		25.70*	25.70*
070 X-RAY SPINE						44.20*	25.70*		46.90*	33.00*
071 X-RAY HIP						31.40*	25.70*		31.00*	28.50*
072 X-RAY UPPER GI TRACT	58.00	45.00*		51.30*	58.00	58.00	59.90*		59.10*	
073 X-RAY COLON						55.90*	51.30*		56.20*	
074 RADIATION THERAPY-LOW VOLT	24.00	26.40				21.30*	21.30*			
075 RADIATION THERAPY-SUPER VOLT	37.20	35.20				17.50	17.50			
076 RADIATION THERAPY-MEGAVOLT						42.00	42.00	42.00		17.50
077 CAT SCAN - HEAD						206.50*	216.50*		42.00	42.00
078 CAT SCAN-HEAD, INTERPRET ONLY						55.00	55.00	55.00	55.00	55.00
079 THREE CHEMISTRY TESTS						21.00	20.50	21.00	21.00	21.00
080 TWELVE CHEMISTRY TESTS						18.00	14.00	12.00	15.00	18.00
081 CULTURE-OTHER THAN BLOOD						10.00	13.00	17.00	12.00	12.00
082 HEMOGLOBIN						4.00	2.25	2.50	4.00	4.00
083 AUTOMATED BLOOD COUNT						8.00	5.50		8.00	
084 WHITE CELL COUNT						3.00	2.25	4.00	3.00	3.00
085 COMPLETE BLOOD COUNT (CBC)						8.50	8.00	13.50	8.00	8.00
086 CHOLESTEROL TEST						7.00	6.50	7.00	7.00	7.00
087 FLOCCULATION TEST						6.00	6.00		6.00	6.00
088 HEVATOCRIT						3.00	2.25	3.00	5.00	4.00
089 PLATELET COUNT (REES-ECKER)						5.45	6.50	9.50	6.00	4.00
090 POTASSIUM TEST						7.00	8.00	7.00	10.00	9.50
091 PROTHROMBIN						6.00	5.50	8.00	5.00	6.00
092 SEDIMENTATION RATE						5.00	4.00	7.50	6.00	4.00
093 BLOOD SUGAR						7.00	6.00	7.00	7.00	8.00
094 SUN-UREA, NITROGEN						7.00	7.00	7.00	7.00	7.00
095 URIC ACID						6.00	6.00	7.50	5.00	6.00
096 FECES-OCULT BLOOD						3.00	5.00	4.00	5.00	4.00
097 PAP TEST						8.00	6.00	12.00	10.00	8.00
098 ROUTINE URINALYSIS						5.00	5.00	5.00	6.00	5.00
099 CHEMICAL URINALYSIS						5.00	5.00	5.00	6.00	5.00
100 PATHOLOGY-THREE SPECIMENS						16.00	17.50			

1979 PREVAILING CHARGE SUMMARY DATA

ARIZONA

AETNA LIFE AND CASUALTY

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

99

99

001	INITIAL BRIEF OFFICE VISIT		21.30*	001
002	INITIAL LIMITED OFFICE VISIT	28.50*	40.00	002
003	INIT INTERMED OFFICE VISIT		21.30*	003
004	INIT COMP OFFICE VISIT	50.00*	50.00	004
005	MINIMAL F/U OFFICE VISIT	6.00*	5.00	005
006	BRIEF F/U OFFICE VISIT	10.00*	10.00*	006
007	LIMITED F/U OFFICE VISIT	14.30*	15.00	007
008	INTERMED F/U OFFICE VISIT	12.00	17.00*	008
009	EXTENDED F/U OFFICE VISIT	25.00	30.00	009
010	COMPLETE F/U OFFICE VISIT	35.00*	49.90*	010
011	BRIEF F/U HOME VISIT	21.30*	21.30	011
012	LIMITED F/U HOME VISIT			012
013	INTERMEDIATE F/U HOME VISIT	20.00		013
014	EXTENDED CARE FACILITY VISIT			014
015	BRIEF F/U NURSING HOME VISIT	10.00*	10.00*	015
016	INITIAL BRIEF HOSPITAL VISIT	35.60*	42.80*	016
017	INIT INTERMED HOSPITAL VISIT		55.00	017
018	INITIAL COMP HOSPITAL VISIT	55.00	50.00	018
019	BRIEF F/U HOSPITAL VISIT	11.40*	10.70*	019
020	LIMITED F/U HOSPITAL VISIT	15.00	15.00	020
021	INTERMED F/U HOSPITAL VISIT	7.20*	7.20*	021
022	EXTENDED F/U HOSPITAL VISIT		12.00	022
023	BRIEF EMERGENCY ROOM VISIT		21.20*	023
024	LIMITED EMERGENCY ROOM VISIT		32.20*	024
025	INTERMED EMERGENCY ROOM VISIT		50.90*	025
026	LIMITED CONSULTATION	27.40*	60.00	026
027	EXTENSIVE CONSULTATION		55.00	027
028	COMPREHENSIVE CONSULTATION		71.40*	028
029	PSYCHOTHERAPY-ONE HOUR		48.90*	029
030	PSYCHOTHERAPY-HALF HOUR		29.30*	030
031	CHIROPRACTIC OFFICE VISIT	11.40*	10.00	031
032	INITIAL PHYSIOTHERAPY			032
033	F/U PODIATRIC OFFICE VISIT		14.30*	033
034	ELECTROCARDIOGRAM (EKG)	28.50*	21.30*	034
035	EKG-INTERPRET. REPORT ONLY	6.00	9.00	035
036	ARTERIAL BLOOD GAS STUDY			036
037	ELECTROENCEPHALOGRAPH (EEG)		71.40*	037
038	CHEMOTHERAPY		15.00	038
039	COLLECTION OF SPECIMENS		3.00	039
040	DEBRIDEMENT OF NAILS			040
041	SKIN BIOPSY		25.70*	041
042	CHEMOCAUTERY		15.00*	042
043	RADICAL MASTECTOMY		678.80*	043
044	OPEN REDUCTION OF FRACTURE		775.70*	044
045	ARTHROCENTESIS-MAJOR JOINT			045
046	ARTHROTOMY	20.00	19.40*	046
047	ARTHROPLASTY-REPAIR OF HIP		1350.00	047
048	NEEDLE PUNCTURE OF BURSA		19.40*	048
049	BRONCHOSCOPY		171.10*	049
050	THORACENTESIS		30.00	050

1979 PREVAILING CHARGE SUMMARY DATA AETNA LIFE AND CASUALTY ARIZONA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

99 99

PROCEDURE DESCRIPTION			
051 CATHETERIZATION OF HEART			051
052 INSERTION OF PACEMAKER			052
053 PARTIAL COLECTOMY		741.40*	053
054 APPENDECTOMY	30.00	436.70*	054
055 SIGMOIDOSCOPY		28.50*	055
056 HEMORRHOIDECTOMY		300.00*	056
057 CHOLECYSTECTOMY		570.40*	057
058 REPAIR HERNIA		356.50*	058
059 DIAGNOSTIC CYSTOURETHROSCOPY		49.90*	059
060 DILATION OF URETHRA		21.30*	060
061 PROSTATECTOMY		755.70*	061
062 ELECTROSECTION-PROSTATE (TUR)		784.30*	062
063 HYSTERECTOMY		639.80*	063
064 INITIAL COMPLETE EYE EXAM		24.00	064
065 COMPREHENSIVE EYE EXAM		28.00	065
066 EYE EXAM WITH TONOMETRY		11.60*	066
067 EXTRACTION OF LENS		713.00*	067
068 CHEST X-RAY, SINGLE VIEW	20.00		068
069 CHEST X-RAY, TWO VIEWS	25.70*		069
070 X-RAY SPINE			070
071 X-RAY HIP			071
072 X-RAY UPPER GI TRACT	55.00		072
073 X-RAY COLON			073
074 RADIATION THERAPY-LOW VOLT			074
075 RADIATION THERAPY-SUPER VOLT			075
076 RADIATION THERAPY-MEGAVOLT	42.00		076
077 CAT SCAN - HEAD			077
078 CAT SCAN-HEAD, INTERPRET ONLY	55.00		078
079 THREE CHEMISTRY TESTS	22.00		079
080 TWELVE CHEMISTRY TESTS	32.55		080
081 CULTURE-OTHER THAN BLOOD	13.50		081
082 HEMOGLOBIN	5.00		082
083 AUTOMATED BLOOD COUNT	8.00		083
084 WHITE CELL COUNT	4.00		084
085 COMPLETE BLOOD COUNT (CBC)	10.00		085
086 CHOLESTEROL TEST	8.00		086
087 FLOCCULATION TEST	6.00		087
088 HEMATOCRIT	4.00		088
089 PLATELET COUNT (REES-ECKER)	7.00		089
090 POTASSIUM TEST	10.00		090
091 PROTHROMBIN	8.00		091
092 SEDIMENTATION RATE	5.60		092
093 BLOOD SUGAR	8.00		093
094 BUN-UREA, NITROGEN	8.00		094
095 URIC ACID	6.00		095
096 FECES-OCCULT BLOOD	5.50		096
097 PAP TEST	10.00		097
098 ROUTINE URINALYSIS	5.20		098
099 CHEMICAL URINALYSIS	5.00		099
100 PATHOLOGY-THREE SPECIMENS			100

ARKANSAS

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LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	SINGLE	SINGLE
001 INITIAL BRIEF OFFICE VISIT	15.00	35.00
002 INITIAL LIMITED OFFICE VISIT		35.00
003 INIT INTERMED OFFICE VISIT		35.00
004 INIT COMP OFFICE VISIT	25.00	70.00
005 MINIMAL F/U OFFICE VISIT	3.00	3.00
006 BRIEF F/U OFFICE VISIT	8.60*	8.60*
007 LIMITED F/U OFFICE VISIT	8.60	8.60
008 INTERMED F/U OFFICE VISIT	10.00	15.00
009 EXTENDED F/U OFFICE VISIT	15.00	30.00
010 COMPLETE F/U OFFICE VISIT	12.00	42.80*
011 BRIEF F/U HOME VISIT	14.30*	14.30*
012 LIMITED F/U HOME VISIT		20.00
013 INTERMEDIATE F/U HOME VISIT	14.30	14.30
014 EXTENDED CARE FACILITY VISIT		15.00*
015 BRIEF F/U NURSING HOME VISIT	8.60	8.60
016 INITIAL BRIEF HOSPITAL VISIT	37.50	42.00
017 INIT INTERMED HOSPITAL VISIT		45.00
018 INITIAL COMP HOSPITAL VISIT	35.00	63.00*
019 BRIEF F/U HOSPITAL VISIT	11.40*	11.40*
020 LIMITED F/U HOSPITAL VISIT	17.10*	25.00
021 INTERMED F/U HOSPITAL VISIT	17.10	35.00
022 EXTENDED F/U HOSPITAL VISIT		21.40*
023 BRIEF EMERGENCY ROOM VISIT		21.40
024 LIMITED EMERGENCY ROOM VISIT		21.40
025 INTERMED EMERGENCY ROOM VISIT	35.00	49.90*
026 LIMITED CONSULTATION		49.90
027 EXTENSIVE CONSULTATION		71.30*
028 COMPREHENSIVE CONSULTATION		48.00
029 PSYCHOTHERAPY-ONE HOUR		25.00
030 PSYCHOTHERAPY-HALF HOUR		8.70
031 CHIROPRACTIC OFFICE VISIT	10.00	17.50
032 INITIAL PHYSIOTHERAPY		11.40
033 F/U PODIATRIC OFFICE VISIT		20.00
034 ELECTROCARDIOGRAM (EKG)	20.00	7.10*
035 EKG-INTERPRET, REPORT ONLY	7.50	53.20
036 ARTERIAL BLOOD GAS STUDY		70.00
037 ELECTROENCEPHALOGRAM (EEG)		15.00
038 CHEMOTHERAPY		5.00
039 COLLECTION OF SPECIMENS		
040 DEBRIDEMENT OF NAILS		21.40*
041 SKIN BIOPSY		35.00
042 CHEMOCAUTERY		710.00
043 RADICAL MASTECTOMY		855.60*
044 OPEN REDUCTION OF FRACTURE		15.00
045 ARTHROCENTESIS-MAJOR JOINT		15.00
046 ARTHROTOMY	15.00	713.00*
047 ARTHROPLASTY-REPAIR OF HIP		20.00
048 NEEDLE PUNCTURE OF BURSA		142.60*
049 BRONCHOSCOPY		35.70*
050 THORACENTESIS		

1979 PREVAILING CHARGE SUMMARY DATA ARKANSAS B/C-B/S

ARKANSAS

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	SINGLE	SINGLE
051 CATHETERIZATION OF HEART		500.00
052 INSERTION OF PACEMAKER		700.00
053 PARTIAL COLECTOMY		713.00*
054 APPENDECTOMY		285.20*
055 SIGMOIDOSCOPY	21.40*	40.00
056 HEMORRHOIDECTOMY		320.90*
057 CHOLECYSTECTOMY		499.10*
058 REPAIR HERNIA		350.00
059 DIAGNOSTIC CYSTOURETHROSCOPY	50.00	50.00
060 DILATION OF URETHRA		14.30*
061 PROSTATECTOMY		570.40*
062 ELECTROSECTION-PROSTATE (TUR)	606.10*	606.10*
063 HYSTERECTOMY		
064 INITIAL COMPLETE EYE EXAM		25.00
065 COMPREHENSIVE EYE EXAM		21.40*
066 EYE EXAM WITH TONOMETRY		10.00
067 EXTRACTION OF LENS	499.10*	499.10*
068 CHEST X-RAY, SINGLE VIEW	17.10	17.00
069 CHEST X-RAY, TWO VIEWS	21.40*	21.40*
070 X-RAY SPINE		28.00
071 X-RAY HIP		21.40*
072 X-RAY UPPER GI TRACT	48.00	49.90*
073 X-RAY COLON		42.80*
074 RADIATION THERAPY-LOW VOLT		
075 RADIATION THERAPY-SUPER VOLT	28.50	28.50*
076 RADIATION THERAPY-MEGAVOLT		30.90
077 CAT SCAN - HEAD		222.40*
078 CAT SCAN-HEAD, INTERPRET ONLY		74.50*
079 THREE CHEMISTRY TESTS		7.00
080 TWELVE CHEMISTRY TESTS		15.00
081 CULTURE-OTHER THAN BLOOD		10.00
082 HEMOGLOBIN		4.00
083 AUTOMATED BLOOD COUNT		10.00
084 WHITE CELL COUNT		4.00
085 COMPLETE BLOOD COUNT (CBC)		10.00
086 CHOLESTEROL TEST		8.00
087 FLOCCULATION TEST		4.60
088 HEMATOCRIT		4.00
089 PLATELET COUNT (REES-ECKER)		6.00
090 POTASSIUM TEST		8.00
091 PROTHROMBIN		7.50
092 SEDIMENTATION RATE		6.00
093 BLOOD SUGAR		8.00
094 BUN-UREA, NITROGEN		8.00
095 URIC ACID		8.00
096 FECES-OCCULT BLOOD		5.00
097 PAP TEST		10.00
098 ROUTINE URINALYSIS		5.00
099 CHEMICAL URINALYSIS		3.00
100 PATHOLOGY-THREE SPECIMENS		21.50

CALIFORNIA

Map of California showing county boundaries and assigned numbers:

- San Francisco: 05-0
- San Francisco: 06
- San Francisco: 07
- San Francisco: 08
- San Francisco: 09
- San Francisco: 10
- San Francisco: 11
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- San Francisco: 99
- San Francisco: 100

Occidental handles non-Medi-Cal claims from
15-28

(For more locality information
see Appendix A)

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA

CALIFORNIA PHYSICIANS SERVICE

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

PSRO-01 PSRO-02 PSRO-03 PSRO-04 PSRO-05

PSRO-01 PSRO-02 PSRO-03 PSRO-04 PSRO-05

001 INITIAL BRIEF OFFICE VISIT	29.00	27.00	24.00	25.00	25.00	20.00	20.00	21.39*	20.00	21.39*	21.39*
002 INITIAL LIMITED OFFICE VISIT	61.00	64.17*	64.17*	64.17*	60.00	28.00	30.00	35.00	30.00	28.00	28.00
003 INIT INTERMED OFFICE VISIT	9.50	8.56*	8.00	8.56*	10.00	43.91*	45.00	42.78*	50.00	49.91*	49.91*
004 INIT COMP OFFICE VISIT	11.41*	11.41*	14.00	11.41*	14.26*	69.87*	8.00	68.45*	66.00	71.30*	71.30*
005 MINIMAL F/U OFFICE VISIT	15.00	15.00	14.26*	16.00*	20.00	12.83*	11.41*	14.26*	12.00	14.00	14.00
006 BRIEF F/U OFFICE VISIT	21.39*	21.00	20.00	20.00	30.00	17.11*	17.11*	17.11*	17.00	17.11*	17.11*
007 LIMITED F/U OFFICE VISIT	29.95*	29.95*	27.50	30.00	30.00	30.00	32.09*	35.65*	30.00	33.00	33.00
008 INTERMED F/U OFFICE VISIT	50.00	49.91*	42.78*	50.00	49.91*	50.00	50.00	49.91*	50.00	49.91*	49.91*
009 EXTENDED F/U OFFICE VISIT	21.39*	21.39*	25.00	21.39*	21.39*	23.40*	21.69*	25.00	25.00	24.10*	24.10*
010 COMPLETE F/U OFFICE VISIT	25.00*	25.00	30.00	29.95*	28.52*	28.52*	28.52*	28.52*	28.52*	30.09*	30.09*
011 LIMITED F/U HOME VISIT	19.25*	19.25*	21.39*	17.98*	20.00	19.93*	16.40*	16.40*	16.40*	19.68*	19.68*
012 INTERMEDIATE F/U HOME VISIT	35.65*	35.65*	35.65	45.00	35.65*	35.65*	35.65*	35.65*	38.00	35.65*	35.65*
013 BRIEF F/U NURSING HOME VISIT	64.17*	59.89*	71.30*	59.89*	62.00	49.91*	50.00	57.04*	49.91*	54.19*	54.19*
014 INITIAL BRIEF HOSPITAL VISIT	14.26*	14.26*	15.00	14.26*	14.26*	75.00	67.02*	71.30*	69.87*	71.30*	71.30*
015 INIT INTERMED HOSPITAL VISIT	18.25	20.00	18.54*	20.00	20.00	14.26*	13.50	16.00	15.00	16.00	16.00
016 LIMITED F/U HOSPITAL VISIT	25.67*	2.13*	22.50	24.00	21.39*	30.00	21.39*	24.24*	25.00	21.39*	21.39*
017 INTERMED F/U HOSPITAL VISIT	35.65*	35.65*	35.65	30.00	35.65*	35.00	35.65*	44.00	30.00	35.65*	35.65*
018 BRIEF F/U HOSPITAL VISIT	35.65*	35.65*	35.65	30.00	35.65*	24.50	21.00	25.00	24.10*	20.00	20.00
019 LIMITED F/U HOSPITAL VISIT	35.65*	35.65*	35.65	30.00	35.65*	32.80*	31.00	32.80	27.38*	30.00	30.00
020 INTERMED F/U HOSPITAL VISIT	35.65*	35.65*	35.65	30.00	35.65*	51.00	51.00	60.00	51.00	49.91*	49.91*
021 EXTENDED F/U HOSPITAL VISIT	35.65*	35.65*	35.65	30.00	35.65*	38.50	35.65*	49.91*	35.00	40.00	40.00
022 BRIEF EMERGENCY ROOM VISIT	35.65*	35.65*	35.65	30.00	35.65*	62.50	55.00	57.04*	56.00	57.04*	57.04*
023 LIMITED EMERGENCY ROOM VISIT	35.65*	35.65*	35.65	30.00	35.65*	80.00	74.87*	85.56*	71.30*	71.30*	71.30*
024 INTERMED EMERGENCY ROOM VISIT	35.65*	35.65*	35.65	30.00	35.65*	49.91*	40.00	49.91*	50.00	49.91*	49.91*
025 LIMITED CONSULTATION	12.83*	16.04*	16.04*	16.04*	16.04*	30.00	30.06*	27.50*	30.00	28.52*	28.52*
026 EXTENSIVE CONSULTATION	29.95*	29.95*	28.52*	29.95*	25.00	13.55*	13.55*	15.31*	11.85*	14.22*	14.22*
027 COMPREHENSIVE CONSULTATION	18.00	15.00	15.00	12.00	15.00	15.00	14.00	14.26*	16.00	14.26*	14.26*
028 PSYCHOTHERAPY-ONE HOUR	29.95*	29.95*	28.52*	29.95*	25.00	27.00	29.95*	28.52*	29.95*	25.00	25.00
029 PSYCHOTHERAPY-HALF HOUR	18.00	15.00	15.00	12.00	15.00	18.75*	17.50	15.00*	14.50	10.00	10.00
030 INITIAL PHYSIOTHERAPY	17.11*	22.50	18.00*	19.96*	22.50	85.27*	85.29*	85.29*	85.29*	85.29*	85.29*
031 CHIROPRACTIC OFFICE VISIT	17.11*	22.50	18.00*	19.96*	22.50	75.81*	68.45*	71.30*	71.30*	60.00	60.00
032 F/U PODIATRIC OFFICE VISIT	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
033 EKG-INTERPRET, REPORT ONLY	3.00	3.00	3.00	3.00	3.00	20.00	20.00	20.00	20.68*	37.00	37.00
034 ARTERIAL BLOOD GAS STUDY	3.00	3.00	3.00	3.00	3.00	35.65*	37.00	33.00	35.65*	5.00	5.00
035 ELECTROENCEPHALOGRAPH (EEG)	3.00	3.00	3.00	3.00	3.00	698.74*	834.21*	898.33*	798.56	1000.00	1000.00
036 CHEMOTHERAPY	3.00	3.00	3.00	3.00	3.00	919.77*	940.73*	1034.85*	952.00	1379.80*	1379.80*
037 COLLECTION OF SPECIMENS	3.00	3.00	3.00	3.00	3.00	24.96*	24.00	20.96*	25.67*	34.22*	34.22*
038 DEBRIDEMENT OF NAILS	3.00	3.00	3.00	3.00	3.00	22.82*	22.82*	22.82*	22.82*	25.00	25.00
039 SKIN BIOPSY	3.00	3.00	3.00	3.00	3.00	1776.81*	1776.81*	454.87*	1776.81*	1776.81*	1776.81*
040 RADICAL MASTECTOMY	3.00	3.00	3.00	3.00	3.00	20.82*	16.68*	20.82*	19.25*	23.99*	23.99*
041 OPEN REDUCTION OF FRACTURE	3.00	3.00	3.00	3.00	3.00	154.01*	171.12*	181.82*	213.90*	213.90*	213.90*
042 ARTHROCENTESIS-MAJOR JOINT	3.00	3.00	3.00	3.00	3.00	30.80	35.00*	35.65*	34.22*	42.78*	42.78*
043 ARTHROTOMY	3.00	3.00	3.00	3.00	3.00						
044 ARTHROPLASTY-REPAIR OF HIP	3.00	3.00	3.00	3.00	3.00						
045 NEEDLE PUNCTURE OF BURSA	3.00	3.00	3.00	3.00	3.00						
046 BRONCHOSCOPY	3.00	3.00	3.00	3.00	3.00						
047 THORACENTESIS	3.00	3.00	3.00	3.00	3.00						

1979 PREVAILING CHARGE SUMMARY DATA CALIFORNIA PHYSICIANS SERVICE

CALIFORNIA

LOCALITY DESIGNATION FOR SPECIALIST

LOCALITY DESIGNATION FOR GENERAL PRACTICE

PROCEDURE DESCRIPTION	PSRO-01	PSRO-02	PSRO-03	PSRO-04	PSRO-05	PSRO-01	PSRO-02	PSRO-03	PSRO-04	PSRO-05
351 CATHETERIZATION OF HEART						449.19*	449.19*	449.19*	449.19*	449.19*
052 INSERTION OF PACEMAKER						1326.69*	1326.69*	1326.69*	1326.69*	1326.69*
053 PARTIAL COLECTOMY						832.78*	888.97*	936.88*	861.87*	999.34*
054 APPENDECTOMY						406.41*	406.41*	474.15*	449.19*	541.88*
055 SIGMOIDOSCOPY	27.45*	29.66*	27.66*	32.94*	32.94*	28.09*	31.23*	31.23*	31.23*	36.81*
056 HEMORRHOIDECTOMY						299.46*	299.46*	385.02*	320.85*	399.28*
057 CHOLECYSTECTOMY						641.70*	682.34*	820.00*	684.48*	855.60*
058 REPAIR HERNIA						421.80*	534.75*	449.19*	476.00	499.10*
059 DIAGNOSTIC CYSTOURETHROSCOPY	54.90*	54.90*	54.90*	54.90*	54.90*	47.49*	52.76*	55.61*	49.62*	63.31*
060 DILATION OF URETHRA						27.00	24.50	22.82*	24.24*	25.00
061 PROSTATECTOMY						798.56*	962.55*	912.64*	962.55*	1212.10*
062 ELECTROSECTION-PROSTATE (TUR)	528.68*	966.59*	1089.78*	980.80*	1137.16*	855.60*	914.64*	998.20*	855.60*	1140.80*
063 HYSTERECTOMY						784.30*	163.99*	898.38*	784.30*	998.20*
064 INITIAL COMPLETE EYE EXAM						35.00	30.00	35.65*	32.00	42.78*
065 COMPREHENSIVE EYE EXAM						39.93*	30.00*	34.22*	30.00*	39.93*
066 EYE EXAM WITH TONOMETRY						14.00	12.12*	16.00	12.83*	17.00
067 EXTRACTION OF LENS	1042.39*	781.80*	852.88*	852.88*	1042.39*	882.98*	750.50*	827.79*	728.40*	1100.00
068 CHEST X-RAY, SINGLE VIEW	20.00	24.24*	22.00	21.39*	18.00	21.39*	18.00	20.50*	20.00	21.39*
069 CHEST X-RAY, TWO VIEWS	29.95*	28.52*	25.67*	27.00	25.00	28.52*	28.52*	28.52*	28.52*	28.52*
070 X-RAY SPINE						57.04*	55.61*	53.48*	61.32*	55.00
071 X-RAY HIP						34.22*	29.95*	35.65*	32.80*	32.09*
072 X-RAY UPPER GI TRACT	55.00	62.54*	55.00	55.00	55.00	64.17*	59.89*	64.17*	69.50	64.17*
073 X-RAY COLON						57.04*	51.34*	59.89*	56.33*	60.61*
074 RADIATION THERAPY-LOW VOLT	30.80*	27.24*	30.80*	30.80*	28.43*	24.81*	24.81*	24.81*	24.81*	24.81*
075 RADIATION THERAPY-SUPER VOLT	37.90*	37.90*	37.90*	37.90*	37.90*	31.36*	31.36*	31.36*	31.36*	28.52*
076 RADIATION THERAPY-MEGAVOLT						48.00	48.00	48.00	48.00	48.00
077 CAT SCAN - HEAD						225.00	225.00	225.00	225.00	225.00
078 CAT SCAN-HEAD, INTERPRET ONLY						90.00	90.00	90.00	90.00	90.00
079 THREE CHEMISTRY TESTS						15.00	30.00	30.00	19.50	24.00
080 TWELVE CHEMISTRY TESTS						15.00	24.20	30.25	36.00	20.00
081 CULTURE-OTHER THAN BLOOD						9.00	10.00	7.50	7.50	7.50
082 HEMOGLOBIN						4.50	4.00	4.25	4.00	4.00
083 AUTOMATED BLOOD COUNT						6.50	10.00	7.50	7.00	7.00
084 WHITE CELL COUNT						3.50	5.00	3.75	3.00	3.00
085 COMPLETE BLOOD COUNT (CBC)						10.00	11.50	12.50	9.00	9.00
086 CHOLESTEROL TEST						10.00	9.25	11.00	8.00	8.00
087 FLOCCULATION TEST						5.10	7.00	9.00	6.00	6.00
088 HEMATOCRIT						4.00	4.00	5.00	3.75	3.75
089 PLATELET COUNT (REES-ECKER)						6.50	8.00	8.25	8.10	8.10
090 POTASSIUM TEST						9.60	9.25	14.00	9.00	9.00
091 PROTHROMBIN						6.70	8.00	8.00	7.00	7.00
092 SEDIMENTATION RATE						5.50	6.00	7.00	7.00	7.00
093 BLOOD SUGAR						10.00	10.00	14.00	8.00	8.00
094 BUN-UREA, NITROGEN						10.40	9.25	14.00	9.00	9.00
095 URIC ACID						10.00	9.50	14.00	8.00	8.00
096 FECES-OCCULT BLOOD						5.00	5.00	5.50	5.00	5.00
097 PAP TEST						10.00	11.00	8.00	5.00	5.00
098 ROUTINE URINALYSIS						5.50	6.00	6.75	5.50	5.50
099 CHEMICAL URINALYSIS						3.00	3.00	3.50	3.50	3.50
100 PATHOLOGY-THREE SPECIMENS						30.00	26.00	25.00	25.00	25.00

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA

CALIFORNIA PHYSICIANS SERVICE

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

PSRO-06 PSRO-07 PSRO-08 PSRO-09 PSRO-10 PSRO-06 PSRO-07 PSRO-08 PSRO-09 PSRO-10

001 INITIAL BRIEF OFFICE VISIT	21.39*	30.00	21.39*	30.00	35.65*	24.24*	24.24*	22.00	21.39*	21.39*	21.39*
002 INITIAL LIMITED OFFICE VISIT	57.04*	59.89*	59.89*	59.89*	59.89*	30.00	35.65*	35.00	35.00	31.50	001
003 INIT INTERMED OFFICE VISIT	9.50	8.00	8.56*	8.40	8.56*	52.50	49.91*	49.91*	49.91*	49.91*	002
004 INIT COMP OFFICE VISIT	14.26*	12.83*	11.41*	12.83*	11.41*	71.30*	71.30*	59.89*	71.30*	75.00	003
005 MINIMAL F/U OFFICE VISIT	14.26*	14.26*	15.97*	14.26*	15.69*	9.98*	8.56*	9.27*	10.00	8.56*	004
006 BRIEF F/U OFFICE VISIT	19.00	18.00	21.39*	18.00	21.39*	16.00	14.26*	11.41*	14.26*	14.26*	005
007 LIMITED F/U OFFICE VISIT	30.00	30.00	29.95*	27.00	29.95*	17.11*	17.11*	17.11*	17.11*	15.69*	006
008 INTERMED F/U OFFICE VISIT	45.00*	49.91*	49.91*	45.00*	40.00*	21.00	21.00	21.39*	18.50	20.00	007
009 EXTENDED F/U OFFICE VISIT	25.00	25.00	21.39*	21.39*	18.54*	35.65*	32.80*	35.00	29.95*	35.65*	008
010 COMPLETE F/U OFFICE VISIT	32.09*	28.52*	30.00	28.52*	25.00*	57.04*	49.91*	53.48*	49.91*	42.78*	009
011 BRIEF F/U HOME VISIT	19.25*	21.39*	19.25*	19.25*	16.04*	25.00	24.00	25.38*	25.00	25.00	010
012 LIMITED F/U HOME VISIT	42.78*	40.00	35.65*	36.00	35.65*	25.38*	30.00	25.38*	25.00	25.38*	011
013 INTERMED F/U HOME VISIT	64.17*	64.17*	64.17*	71.30*	59.89*	28.52*	28.52*	28.52*	28.52*	28.52*	012
014 EXTENDED CARE FACILITY VISIT	17.11*	14.26*	14.26*	14.26*	12.83*	18.00	20.25	15.26*	18.54*	15.26*	013
015 BRIEF F/U NURSING HOME VISIT	19.96*	19.96*	21.00	18.54*	18.20	21.82*	20.00	21.25*	21.82*	21.82*	014
016 INITIAL BRIEF HOSPITAL VISIT	20.00	18.00*	22.10*	21.39*	29.95*	42.78*	40.00	35.65*	42.00	42.78*	015
017 INIT INTERMED HOSPITAL VISIT	64.17*	64.17*	64.17*	71.30*	59.89*	49.91*	49.91*	51.34*	53.48*	51.34*	016
018 INITIAL COMP HOSPITAL VISIT	17.11*	14.26*	14.26*	14.26*	12.83*	71.30*	71.30*	69.87*	71.30*	59.89*	017
019 BRIEF F/U HOSPITAL VISIT	19.96*	19.96*	21.00	18.54*	18.20	20.00	17.11*	14.26*	20.00	14.26*	018
020 LIMITED F/U HOSPITAL VISIT	20.00	18.00*	22.10*	21.39*	29.95*	21.39*	20.00	19.96*	21.39*	19.96*	019
021 INTERMED F/U HOSPITAL VISIT	35.65*	37.00	32.09*	36.00	35.65*	21.39*	21.39*	22.10*	21.39*	21.39*	020
022 EXTENDED F/U HOSPITAL VISIT	14.00	15.00	16.04*	11.76*	16.04*	42.78*	30.00*	35.65*	40.00	40.00*	021
023 BRIEF EMERGENCY ROOM VISIT	25.67*	28.52*	29.95*	28.00	28.52*	27.38*	25.00	25.00	22.50	25.00	022
024 LIMITED EMERGENCY ROOM VISIT	15.00	15.00	15.00	15.00	15.00	32.80*	37.65*	27.38*	32.80*	32.80*	023
025 INTERMED EMERGENCY ROOM VISIT						57.04*	53.48*	51.00	42.78*	51.00	024
026 LIMITED CONSULTATION						42.78*	45.00	29.95*	35.65*	42.78*	025
027 EXTENSIVE CONSULTATION						64.17*	64.17*	49.91*	57.04*	57.04*	026
028 COMPREHENSIVE CONSULTATION						85.00	74.87*	69.87*	71.30*	69.87*	027
029 PSYCHOTHERAPY-ONE HOUR						49.91*	49.91*	50.00	49.91*	55.00	028
030 PSYCHOTHERAPY-HALF HOUR						27.00	24.96*	25.00	25.00	27.50	029
031 CHIROPRACTIC OFFICE VISIT						12.83*	12.83*	10.70*	12.83*	11.37*	030
032 INITIAL PHYSIOTHERAPY						11.37*	15.16*	15.16*	14.22*	16.11*	031
033 F/U PODIATRIC OFFICE VISIT						14.26*	15.00	15.00	14.26*	12.00	032
034 ELECTROCARDIOGRAM (EKG)						25.00	29.95*	29.95*	25.00	25.67*	033
035 EKG-INTERPRET, REPORT ONLY						16.39*	17.50	17.50	12.00	15.00	034
036 ARTERIAL BLOOD GAS STUDY						85.29*	85.29*	85.29*	85.29*	85.29*	035
037 ELECTROENCEPHALOGRAM (EEG)						55.00	71.30*	71.30*	71.30*	71.30*	036
038 CHEMOTHERAPY											037
039 COLLECTION OF SPECIMENS						3.00	3.00	3.00	3.00	3.00	038
040 DEBRIDEMENT OF NAILS						20.00	20.00	20.00	20.00	20.00	039
041 SKIN BIOPSY						32.80*	35.00*	35.65*	36.00	30.00	040
042 CHEMOCAUTERY						6.00	6.70	6.70	6.70	6.70	041
043 RADICAL MASTECTOMY						926.90*	855.60*	770.04*	926.90*	898.38*	042
044 OPEN REDUCTION OF FRACTURE						1149.78*	1095.59*	919.77*	1217.66*	919.77*	043
045 ARTHROCENTESIS-MAJOR JOINT						33.00	24.24*	21.39*	28.52*	30.00	044
046 ARTHROTOMY						22.82*	20.00	22.82*	16.50	22.82*	045
047 ARTHROPLASTY-REPAIR OF HIP						1776.81*	1776.81*	1776.81*	1776.81*	1776.81*	046
048 NEEDLE PUNCTURE OF BURSA						20.82*	20.82*	20.82*	20.82*	20.82*	047
049 BRONCHOSCOPY						213.90*	213.90*	213.90*	213.90*	213.90*	048
050 THORACENTESIS						38.50*	38.50*	38.50*	45.00	38.50*	049
											050

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA

CALIFORNIA PHYSICIANS SERVICE

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-06	PSRO-07	PSRO-08	PSRO-09	PSRO-10	PSRO-06	PSRO-07	PSRO-08	PSRO-09	PSRO-10
051 CATHETERIZATION OF HEART						449.19*	449.19*	449.19*	449.19*	449.19*
052 INSERTION OF PACEMAKER						1326.69*	1326.69*	1326.69*	1326.69*	1326.69*
053 PARTIAL COLECTOMY						1087.90*	936.88*	749.51*	936.88*	787.01*
054 APPENDECTOMY						487.69*	513.36*	474.15*	470.80*	474.15*
055 SIGMOIDOSCOPY	32.94*	32.94*	32.94*	27.45*	32.94*	31.23*	36.51*	28.09*	31.23*	36.51*
056 HEMORRHOIDECTOMY						399.28*	392.15*	342.24*	456.32*	385.02*
057 CHOLECYSTECTOMY						820.00	727.26*	620.31*	759.35*	684.48*
058 REPAIR HERNIA						499.10*	449.19*	392.15*	449.19*	392.15*
059 DIAGNOSTIC CYSTOURETHROSCOPY	54.90*	54.90*	56.00	54.90*	56.00*	58.04*	60.18*	55.00	57.04*	56.00*
060 DILATION OF URETHRA						21.39*	18.54*	25.00	22.00	22.00
061 PROSTATECTOMY						962.55*	998.20*	962.55*	998.20*	962.55*
062 ELECTROSECTION-PROSTATE (TUR)	1137.16*	1089.78*	1061.34*	1137.16*	1042.39*	1140.80*	926.90*	969.68*	941.16*	969.68*
063 HYSTERECTOMY						998.20*	819.95*	770.04*	855.60*	855.60*
064 INITIAL COMPLETE EYE EXAM						36.00	35.65*	39.93*	35.65*	40.00
065 COMPREHENSIVE EYE EXAM						34.22*	35.00*	34.22*	28.52*	35.00*
066 EYE EXAM WITH TONOMETRY						14.26*	14.26*	14.26*	14.26*	14.26*
067 EXTRACTION OF LENS	947.63*	947.63*	900.25*	947.63*	947.63*	938.17*	938.17*	882.98*	882.98*	772.61*
068 CHEST X-RAY, SINGLE VIEW	20.75*	17.50	21.29*	20.00	21.39*	21.39*	22.00	19.50	20.00	18.00
069 CHEST X-RAY, TWO VIEWS	25.67*	25.67*	25.67*	27.00	27.09*	29.95*	27.09*	27.81*	28.52*	27.00
070 X-RAY SPINE						57.00	57.04*	55.61*	59.89*	57.04*
071 X-RAY HIP						34.22*	33.00	32.09*	34.22*	34.22*
072 X-RAY UPPER GI TRACT	55.00	55.00	55.00	55.00	55.00	68.45*	49.91*	54.19*	64.88*	64.17*
073 X-RAY COLON						68.45*	63.81*	55.61*	57.04*	57.00
074 RADIATION THERAPY-LOW VOLT	30.80*	22.74*	30.80*	22.74*	30.80*	24.81*	24.81*	24.81*	24.81*	24.81*
075 RADIATION THERAPY-SUPER VOLT	37.90*	37.90*	37.90*	37.90*	37.90*	31.36*	31.36*	31.36*	31.36*	31.36*
076 RADIATION THERAPY-MEGAVOLT						48.00	48.00	48.00	48.00	48.00
077 CAT SCAN - HEAD						225.00	225.00	225.00	225.00	225.00
078 CAT SCAN-HEAD, INTERPRET ONLY						90.00	90.00	90.00	90.00	90.00
079 THREE CHEMISTRY TESTS						10.50	17.50	16.50	18.00	20.00
080 TWELVE CHEMISTRY TESTS						18.00	21.50	22.00	19.00	20.00
081 CULTURE-OTHER THAN BLOOD						9.00	10.00	10.00	8.00	10.00
082 HEMOGLOBIN						5.00	5.00	5.00	4.50	5.00
083 AUTOMATED BLOOD COUNT						7.50	6.00	7.00	5.50	5.50
084 WHITE CELL COUNT						4.75	5.00	5.00	3.50	5.00
085 COMPLETE BLOOD COUNT (CBC)						10.50	11.00	15.00	10.50	10.00
086 CHOLESTEROL TEST						10.00	9.50	8.25	8.00	12.00
087 FLOCCULATION TEST						5.00	8.00	7.50	6.00	6.25
088 HEMATOCRIT						4.75	4.00	5.50	4.00	5.00
089 PLATELET COUNT (REES-ECKER)						8.80	8.00	8.00	7.00	7.00
090 POTASSIUM TEST						8.00	8.00	8.25	9.00	10.00
091 PROTHROMBIN						7.00	6.50	7.00	7.50	7.50
092 SEDIMENTATION RATE						9.00	8.50	8.25	6.00	6.00
093 BLOOD SUGAR						9.50	8.50	8.25	9.00	9.00
094 BUN-UREA, NITROGEN						8.00	9.00	8.25	8.00	9.00
095 URIC ACID						5.00	6.50	7.00	5.50	4.00
096 FECES-OCCULT BLOOD						10.00	10.00	10.00	8.00	8.00
097 PAP TEST						6.00	6.00	6.00	6.00	5.50
098 ROUTINE URINALYSIS						4.00	3.00	4.00	4.00	3.40
099 CHEMICAL URINALYSIS						25.00	25.00	28.00	25.00	30.00
100 PATHOLOGY-THREE SPECIMENS										

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA PHYSICIANS SERVICE

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

PSRO-11 PSRO-12 PSRO-13 PSRO-14 PSRO-15

PSRO-11 PSRO-12 PSRO-13 PSRO-14 PSRO-15

001 INITIAL BRIEF OFFICE VISIT	35.65*	25.00	32.00	28.00	30.00	19.96*	21.39*	21.19*	22.82*	25.00	001
002 INITIAL LIMITED OFFICE VISIT						35.65*	30.00	35.00	35.65*	35.00	002
003 INIT INTERMED OFFICE VISIT						42.78*	49.91*	49.91*	49.91*	49.91*	003
004 INIT COMP OFFICE VISIT	59.89*	63.00	51.34*	50.00	70.00	58.89*	75.00	70.00	68.45*	70.00	004
005 MINIMAL F/U OFFICE VISIT	8.56*	9.00	9.13*	9.50	10.00	7.50	7.00	8.00	9.98*	9.98*	005
006 BRIEF F/U OFFICE VISIT	11.41*	11.41*	9.98*	11.41*	11.41*	11.41*	13.00	11.41*	11.41*	15.00	006
007 LIMITED F/U OFFICE VISIT	15.69*	15.69*	17.11*	17.11*	15.00	15.69*	16.00	17.11*	15.69*	15.69*	007
008 INTERMED F/U OFFICE VISIT	21.39*	21.39*	17.11*	21.39*	20.00	21.39*	20.00	17.83*	22.00	19.00	008
009 EXTENDED F/U OFFICE VISIT	29.95*	25.00	28.52*	34.22*	36.00	29.95*	29.95*	28.52*	34.22*	42.78*	009
010 COMPLETE F/U OFFICE VISIT	42.78*	36.00	34.94*	39.93*	49.91*	42.78*	57.04*	49.91*	35.65*	49.91*	010
011 BRIEF F/U HOME VISIT	21.39*	19.96*	21.39*	21.39*	21.39*	25.00	21.00	21.82*	25.00	25.53*	011
012 LIMITED F/U HOME VISIT						29.38*	28.00	27.38*	25.38*	30.00	012
013 INTERMEDIATE F/U HOME VISIT	28.52*	32.09*	28.52*	29.52*	25.00	29.52*	25.67*	28.52*	28.52*	34.31*	013
014 EXTENDED CARE FACILITY VISIT						14.69*	16.40*	19.11*	16.40*	17.25*	014
015 BRIEF F/U NURSING HOME VISIT	19.25*	19.25*	19.25*	21.39*	16.97*	20.00	19.68*	21.82*	21.82*	20.00	015
016 INITIAL BRIEF HOSPITAL VISIT	35.65*	35.65*	32.09*	35.65*	35.65*	35.65*	35.00	29.95*	35.65*	35.65*	016
017 INIT INTERMED HOSPITAL VISIT						51.34*	55.00	42.78*	57.04*	50.00	017
018 INITIAL COMP HOSPITAL VISIT	59.89*	64.17*	60.00	68.45*	71.30*	59.89*	71.30*	71.30*	68.45*	75.00	018
019 BRIEF F/U HOSPITAL VISIT	11.41*	14.26*	11.41*	14.26*	14.26*	11.41*	13.00*	12.83*	14.26*	15.00	019
020 LIMITED F/U HOSPITAL VISIT	19.96*	19.96*	17.11*	17.11*	19.96*	17.11*	19.00	21.39*	21.39*	19.96*	020
021 INTERMED F/U HOSPITAL VISIT	29.95*	24.00*	21.39*	25.00	28.52*	24.00*	28.52*	21.39*	34.22*	21.39*	021
022 EXTENDED F/U HOSPITAL VISIT						34.22*	42.50	35.65*	34.22*	35.65*	022
023 BRIEF EMERGENCY ROOM VISIT						21.82*	25.00	25.00	25.00	21.53*	023
024 LIMITED EMERGENCY ROOM VISIT						32.80*	27.38*	32.80*	32.80*	32.37*	024
025 INTERMED EMERGENCY ROOM VISIT						51.00	51.00	51.00	51.00	50.00	025
026 LIMITED CONSULTATION	35.65*	34.22*	32.09*	36.65*	35.65*	35.65*	30.00	42.78*	35.65*	40.00	026
027 EXTENSIVE CONSULTATION						49.91*	49.91*	57.04*	57.04*	53.48*	027
028 COMPREHENSIVE CONSULTATION						69.87*	75.00	69.87*	79.86*	85.00	028
029 PSYCHOTHERAPY-ONE HOUR						55.00	50.00	50.11*	49.91*	50.00	029
030 PSYCHOTHERAPY-HALF HOUR						30.06*	27.00	28.52*	28.52*	30.00	030
031 CHIROPRACTIC OFFICE VISIT	16.04*	16.04*	16.04*	16.04*	15.83*	10.70*	10.70*	10.00	10.70*	10.55*	031
032 INITIAL PHYSIOTHERAPY						11.85*	13.26*	11.37*	10.42*	12.00*	032
033 F/U PODIATRIC OFFICE VISIT						14.00	15.69*	14.00	14.26*	14.00	033
034 ELECTROCARDIOGRAM (EKG)	29.95*	28.00	29.95*	32.09*	29.95*	29.95*	26.00	25.67*	34.22*	28.00	034
035 EKG-INTERPRET-REPORT ONLY	15.00	14.97*	15.00	15.00	15.00	20.00	12.50	12.83*	15.00*	15.00	035
036 ARTERIAL BLOOD GAS STUDY						85.29*	85.29*	85.29*	85.29*	72.93*	036
037 ELECTROENCEPHALOGRAPH (EEG)						71.30*	71.30*	71.30*	68.45*	75.00	037
038 CHEMOTHERAPY											038
039 COLLECTION OF SPECIMENS						3.00	3.00	3.00	3.00	3.00	039
040 DEBRIDEMENT OF NAILS						20.00	20.00	20.75*	20.00	19.96*	040
041 SKIN BIOPSY						35.65*	34.22*	34.22*	35.65*	36.36*	041
042 CHEMOCAUTERY						6.70	6.70	6.70	6.70	5.50	042
043 RADICAL MASTECTOMY						698.74*	855.60*	898.38*	898.38*	855.60*	043
044 OPEN REDUCTION OF FRACTURE						919.77*	1009.75*	1120.04*	1087.04*	1140.80*	044
045 ARTHROCENTESIS-MAJOR JOINT						21.39*	21.39*	32.09*	26.00	28.52*	045
046 ARTHROTOMY						22.82*	18.16*	22.82*	22.82*	20.00	046
047 ARTHROPLASTY-REPAIR OF HIP						1776.81*	1776.81*	1776.81*	1776.81*	2000.00	047
048 NEEDLE PUNCTURE OF BURSA						18.63*	20.82*	20.82*	20.82*	25.00	048
049 BRONCHOSCOPY						213.90*	213.90*	213.90*	213.90*	192.51	049
050 THORACENTESIS						38.50*	35.65*	38.50*	38.50*	49.91*	050

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA

CALIFORNIA PHYSICIANS SERVICE

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-11	PSRO-12	PSRO-13	PSRO-14	PSRO-15
051 CATHETERIZATION OF HEART	449.19*	449.19*	449.19*	450.00*	550.00
052 INSERTION OF PACEMAKER	1326.69*	1326.69*	1326.69*	1326.69*	891.25*
053 PARTIAL COLECTOMY	832.78*	936.88*	936.88*	899.38*	912.64*
054 APPENDECTOMY	399.28*	456.32*	474.15*	474.15*	456.32
055 SIGMOIDOSCOPY	31.23*	31.23*	27.09*	31.23*	38.50*
056 HEMORRHOIDECTOMY	299.46*	385.02*	385.02*	385.02*	396.00
057 CHOLECYSTECTOMY	598.92*	713.00*	713.00*	641.70*	752.93*
058 REPAIR HERNIA	392.15*	399.28*	399.28*	385.02*	474.86*
059 DIAGNOSTIC CYSTOURETHROSCOPY	55.00	52.76*	52.76*	47.49*	57.04*
060 DILATION OF URETHRA	32.09*	30.00	25.00	21.39*	22.82*
061 PROSTATECTOMY	800.00*	998.20*	962.55*	962.55*	1100.00
062 ELECTROSECTION-PROSTATE (TUR)	798.56*	998.20*	969.68*	855.60*	969.68*
063 HYSTERECTOMY	855.60*	995.02*	855.60*	713.00*	962.55*
064 INITIAL COMPLETE EYE EXAM	39.93*	35.65*	28.52*	28.52*	30.40
065 COMPREHENSIVE EYE EXAM	34.22*	34.22*	28.52*	36.00*	30.00*
066 EYE EXAM WITH TONOMETRY	14.26*	15.00	14.00	12.75*	14.97*
067 EXTRACTION OF LENS	993.35*	882.98*	772.61*	816.81*	864.16*
068 CHEST X-RAY, SINGLE VIEW	19.96*	21.46*	21.39*	21.39*	18.00
069 CHEST X-RAY, TWO VIEWS	25.67*	28.52*	28.00	32.09*	28.00
070 X-RAY SPINE	55.00	57.04*	57.04	64.17*	55.61
071 X-RAY HIP	32.50	32.00	34.22*	38.00	32.00
072 X-RAY UPPER GI TRACT	64.17*	64.17*		64.17*	64.17*
073 X-RAY COLON	55.50	56.00		57.04*	51.34*
074 RADIATION THERAPY-LOW VOLT	24.81*	24.81*		24.81*	31.66*
075 RADIATION THERAPY-SUPER VOLT	31.36*	31.36*		35.00*	39.93*
076 RADIATION THERAPY-MEGAVOLT	48.00	48.00	48.00	48.00	48.00
077 CAT SCAN - HEAD	225.00	225.00	225.00	225.00	225.00
078 CAT SCAN-HEAD, INTERPRET ONLY	90.00	90.00	90.00	90.00	90.00
079 THREE CHEMISTRY TESTS	24.00	15.00	20.00	20.00	20.00
080 TWELVE CHEMISTRY TESTS	22.00	18.50	30.00	19.00	19.50
081 CULTURE-OTHER THAN BLOOD	8.00	7.00	7.00	12.00	7.50
082 HEMOGLOBIN	4.00	3.75	4.00	4.80	5.00
083 AUTOMATED BLOOD COUNT	8.00	4.00	9.00	7.00	6.50
084 WHITE CELL COUNT	4.00	3.00	4.00	4.20	4.50
085 COMPLETE BLOOD COUNT (CBC)	10.50	9.50	9.25	12.40	10.50
086 CHOLESTEROL TEST	9.00	8.00	8.00	12.00	8.50
087 FLOCCULATION TEST	5.00	6.50	5.50	6.00	7.00
088 HEMATOCRIT	4.00	5.00	4.50	5.00	5.00
089 PLATELET COUNT (REES-ECKER)	6.00	7.00	4.50	6.75	8.00
090 POTASSIUM TEST	9.00	9.00	6.50	10.00	8.00
091 PROTHROMBIN	7.50	6.50	7.00	7.75	7.00
092 SEDIMENTATION RATE	6.00	6.00	6.00	6.50	6.00
093 BLOOD SUGAR	8.50	8.00	8.00	11.00	8.00
094 BUN-UREA,NITROGEN	8.50	8.00	7.00	12.00	9.00
095 URIC ACID	9.00	8.00	8.00	11.00	8.50
096 FECES-OCCULT BLOOD	4.00	5.00	6.00	8.00	6.00
097 PAP TEST	12.00	8.00	12.00	10.00	10.00
098 ROUTINE URINALYSIS	5.00	5.00	5.00	6.00	6.00
099 CHEMICAL URINALYSIS	4.00	4.00	3.50	5.00	3.50
100 PATHOLOGY-THREE SPECIMENS	20.00	25.00	25.00	31.00	24.00

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA PHYSICIANS SERVICE

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LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

PSRO-16 PSRO-17 PSRO-18 PSRO-19 PSRO-20

001 INITIAL BRIEF OFFICE VISIT	25.00	24.00	30.00	27.00	29.00	22.00	18.00	25.00	25.00	25.00	001
002 INITIAL LIMITED OFFICE VISIT						30.00	30.00	35.00	35.00	30.00	002
003 INIT INTERMED OFFICE VISIT						50.00	57.04*	57.04*	42.78*	49.91*	003
004 INIT COMP OFFICE VISIT	53.00	60.00	70.00	64.17*	75.00	71.30*	74.15*	71.30*	71.30*	71.30*	004
005 MINIMAL F/U OFFICE VISIT	9.98*	8.00	9.00	10.00	10.00	9.00	9.13*	10.00	10.00	10.00	005
006 BRIEF F/U OFFICE VISIT	12.12*	11.41*	14.26*	14.26*	14.26*	14.26*	17.11*	17.83*	17.11*	17.11*	006
007 LIMITED F/U OFFICE VISIT	15.00	15.00	17.83*	17.11*	17.11*	17.83*	18.54*	20.00	17.11*	20.00	007
008 INTERMED F/U OFFICE VISIT	20.00	17.00	20.00	20.00	20.00	20.00	24.00	21.39*	20.00	22.00	008
009 EXTENDED F/U OFFICE VISIT	25.00	28.00	30.00	30.00	30.00	33.00	20.00	30.00	35.00	25.00	009
010 COMPLETE F/U OFFICE VISIT	49.91*	48.48*	62.50	49.91*	49.91*	53.48*	48.48*	57.04*	65.00	59.18*	010
011 BRIEF F/U HOME VISIT	20.00	20.00	28.52*	25.00	28.52*	25.53*	25.53*	20.00	25.00	25.53*	011
012 LIMITED F/U HOME VISIT	29.95*	28.52*	28.52*	35.00	28.52*	34.31*	34.31*	30.00	34.31*	30.00	012
013 INTERMEDIATE F/U HOME VISIT						15.00	14.00	20.00	18.89*	21.00	013
014 EXTENDED CARE FACILITY VISIT	18.97*	20.00*	20.00	21.10*	21.10*	17.25*	20.00	21.53*	21.10*	21.53*	014
015 BRIEF F/U NURSING HOME VISIT	36.36*	35.65*	49.91*	40.00	49.91*	38.50*	35.65*	49.91*	49.91*	49.91*	015
016 INITIAL BRIEF HOSPITAL VISIT						57.04*	57.04*	65.00	64.17*	68.45*	016
017 INIT INTERMED HOSPITAL VISIT						71.30*	75.00	71.30*	71.30*	71.30*	017
018 INITIAL COMP HOSPITAL VISIT	60.00	68.45*	75.00	71.30	75.00	14.26*	15.00	20.00	20.00	20.00	018
019 BRIEF F/U HOSPITAL VISIT	14.26*	14.26*	20.00	17.11	20.00	21.39*	22.00	21.39*	22.82*	25.00	019
020 LIMITED F/U HOSPITAL VISIT	18.00	20.00	20.00	20.00	22.82	21.39*	26.29	21.39*	21.39*	25.00*	020
021 INTERMED F/U HOSPITAL VISIT	25.00	21.39	21.39*	16.00*	25.00	33.00	45.00	35.00*	30.00*	28.52*	021
022 EXTENDED F/U HOSPITAL VISIT						21.53*	20.00	26.95*	26.95*	26.95*	022
023 BRIEF EMERGENCY ROOM VISIT						29.18*	32.37*	29.09*	35.65*	26.95*	023
024 LIMITED EMERGENCY ROOM VISIT						50.00	50.00	50.00	50.00	50.00	024
025 INTERMED EMERGENCY ROOM VISIT	35.65*	37.50	37.50	37.50	37.50	38.50*	49.91*	40.00	57.04*	43.00	025
026 LIMITED CONSULTATION						64.17*	57.04*	60.00	60.00	71.30*	026
027 EXTENSIVE CONSULTATION						78.43*	81.28*	100.00	85.56*	92.69*	027
028 COMPREHENSIVE CONSULTATION						49.91*	50.00	60.00	50.00	57.04*	028
029 PSYCHOTHERAPY-ONE HOUR						35.00	30.00	30.00	35.65*	35.65*	029
030 PSYCHOTHERAPY-HALF HOUR						10.55*	12.69*	12.69*	12.69*	14.59*	030
031 CHIROPRACTIC OFFICE VISIT	15.00*	21.10*	12.69*	12.69*	13.40*	11.67*	12.00*	11.67*	11.67*	11.67*	031
032 INITIAL PHYSIOTHERAPY						18.00	15.00	20.00	18.00	18.00	032
033 F/U PODIATRIC OFFICE VISIT						30.00	30.00	28.52*	30.00	30.00	033
034 ELECTROCARDIOGRAM (EKG)	28.00	32.00	29.95*	29.95*	29.95*	13.50*	15.00	15.00	14.26*	14.26*	034
035 EKG-INTERPRET, REPORT ONLY	15.00	15.00	15.00	15.00	15.00	72.93*	72.93*	72.93*	72.93*	97.22*	035
036 ARTERIAL BLOOD GAS STUDY						75.00	70.00	90.00	77.77*	65.00	036
037 ELECTROENCEPHALOGRAPH (EEG)						3.00	3.00	3.00	3.00	3.00	037
038 CHEMOTHERAPY						19.96*	19.96*	25.00	19.96*	24.52*	038
039 COLLECTION OF SPECIMENS						36.36*	36.36*	45.00	30.00	36.36*	039
040 DEBRIDEMENT OF NAILS						6.00	6.00	6.00	6.00	6.00	040
041 SKIN BIOPSY						1083.76*	1026.72*	1212.10*	1078.06*	1069.50*	041
042 CHEMOCAUTERY						1098.02*	1195.27*	1283.40*	1314.77*	1303.93*	042
043 RADICAL MASTECTOMY						28.52*	28.00	30.00	25.00*	28.52*	043
044 OPEN REDUCTION OF FRACTURE						20.00	20.00	20.00	25.00	20.00	044
045 ARTHROCENTESIS-MAJOR JOINT						2000.00	2000.00	2000.00	2000.00	2000.00	045
046 ARTHROTOMY						25.00	25.00	25.00	17.50	21.96*	046
047 ARTHROPLASTY-REPAIR OF HIP						192.51*	192.51*	192.51*	192.51*	225.00*	047
048 NEEDLE PUNCTURE OF BURSA						49.91*	49.91*	49.91*	49.91*	50.00	048
049 BRONCHOSCOPY											049
050 THORACENTESIS											050

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA

CALIFORNIA PHYSICIANS SERVICE

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

PSRO-16 PSRO-17 PSRO-18 PSRO-19 PSRO-20

PSRO-16 PSRO-17 PSRO-18 PSRO-19 PSRO-20

051	CATHERIZATION OF HEART	570.40*	520.00	570.40*	570.40*	570.40*	550.00	051
052	INSERTION OF PACEMAKER	960.00*	1000.00*	1000.00*	1000.00*	1000.00*	891.25*	052
053	PARTIAL COLECTOMY	1040.00	969.68*	1140.80*	1098.02*	1098.02*	1250.00	053
054	APPENDECTOMY	513.36*	513.36*	513.36*	513.36*	513.36*	513.36*	054
055	SIGMOIDOSCOPY	34.22*	38.50*	36.72*	35.94*	35.94*	39.50*	055
056	HEMORRHOIDECTOMY	427.80*	427.80*	427.80*	427.80*	427.80*	427.80*	056
057	CHOLECYSTECTOMY	820.00	784.30*	916.92*	855.60*	926.90	926.90	057
058	REPAIR HERNIA	539.03	539.03*	570.40*	570.40*	570.40*	570.40	058
059	DIAGNOSTIC CYSTOURETHROSCOPY	59.89*	61.03*	71.30*	60.00	71.30*	71.30*	059
060	DILATION OF URETHRA	24.24*	21.00	22.82*	30.00	24.24*	24.24*	060
061	PROSTATECTOMY	1140.80*	1140.80*	1188.57*	1197.84*	1180.02*	1180.02*	061
062	ELECTROSECTION-PROSTATE (TUR)	1140.80*	912.64*	1212.10*	1050.00	1200.00	1200.00	062
063	HYSTERECTOMY	962.55*	962.55*	998.20*	1050.00	38.40	38.40	063
064	INITIAL COMPLETE EYE EXAM	35.00	34.00	36.00	37.43*	34.22	34.22	064
065	COMPREHENSIVE EYE EXAM	40.00	34.22*	42.78*	37.08*	34.22	34.22	065
066	EYE EXAM WITH TONOMETRY	14.26*	14.97*	15.00	15.00*	14.26*	14.26*	066
067	EXTRACTION OF LENS	950.00	998.20*	1100.00	1140.80*	1234.49*	1234.49*	067
068	CHEST X-RAY, SINGLE VIEW	20.00	21.39*	22.00	22.00	22.00*	22.00*	068
069	CHEST X-RAY, TWO VIEWS	29.95*	32.09*	27.00	32.09*	29.95*	29.95*	069
070	X-RAY SPINE	60.00	69.52*	60.00	65.00	60.00	60.00	070
071	X-RAY HIP	35.00	37.50*	30.00	37.50*	33.00	33.00	071
072	X-RAY UPPER GI TRACT	69.87*	71.00	66.00	71.00	72.01*	72.01*	072
073	X-RAY COLON	64.17*	64.17*	60.00	68.00	67.00	67.00	073
074	RADIATION THERAPY-LOW VOLT	31.66*	31.66*	31.66*	31.66*	31.66*	31.66*	074
075	RADIATION THERAPY-SUPER VOLT	39.93*	42.78*	39.93*	42.78*	39.93*	39.93*	075
076	RADIATION THERAPY-MEGAVOLT	48.00	48.00	48.00	48.00	48.00	48.00	076
077	CAT SCAN - HEAD	225.00	225.00	225.00	225.00	225.00	225.00	077
078	CAT SCAN-HEAD, INTERPRET ONLY	90.00	90.00	90.00	90.00	90.00	90.00	078
079	THREE CHEMISTRY TESTS	22.00	15.90	20.50	22.50	15.00	15.00	079
080	TWELVE CHEMISTRY TESTS	22.50	25.00	20.00	24.00	20.00	20.00	080
081	CULTURE-OTHER THAN BLOOD	10.75	10.00	10.00	8.50	10.00	10.00	081
082	HEMOGLOBIN	5.00	4.00	4.00	5.00	5.00	5.00	082
083	AUTOMATED BLOOD COUNT	5.50	7.00	9.00	4.00	6.00	6.00	083
084	WHITE CELL COUNT	5.00	7.00	3.00	5.00	5.50	5.50	084
085	COMPLETE BLOOD COUNT (CBC)	13.25	10.00	9.50	10.00	10.00	10.00	085
086	CHOLESTEROL TEST	9.50	9.00	8.00	9.00	9.00	9.00	086
087	FLOCCULATION TEST	9.50	6.70	4.00	10.00	8.50	8.50	087
088	HEMATOCRIT	5.00	4.00	4.50	5.00	5.00	5.00	088
089	PLATELET COUNT (REES-ECKER)	7.50	10.00	5.00	10.50	7.40	7.40	089
090	POTASSIUM TEST	13.25	8.40	8.40	9.50	8.40	8.40	090
091	PROTHROMBIN	8.00	8.00	6.50	7.00	8.00	8.00	091
092	SEDIMENTATION RATE	7.20	6.00	6.00	6.00	6.00	6.00	092
093	BLOOD SUGAR	11.00	9.00	8.50	10.00	8.40	8.40	093
094	BUN-UREA-NITROGEN	9.00	8.40	8.00	9.00	9.00	9.00	094
095	URIC ACID	10.00	9.00	8.50	9.00	8.50	8.50	095
096	FECES-OCULT BLOOD	5.00	6.00	6.00	5.00	7.00	7.00	096
097	PAP TEST	10.00	10.00	12.50	10.00	10.00	10.00	097
098	ROUTINE URINALYSIS	6.50	6.00	6.00	6.00	6.00	6.00	098
099	CHEMICAL URINALYSIS	6.00	4.00	5.00	4.00	5.00	5.00	099
100	PATHOLOGY-THREE SPECIMENS	35.00	22.00	20.00	26.00	25.00	25.00	100

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA

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LOCALITY DESIGNATION FOR SPECIALIST

LOCALITY DESIGNATION FOR GENERAL PRACTICE

PROCEDURE DESCRIPTION

PSRO-21 PSRO-22 PSRO-23 PSRO-24 PSRO-25 PSRO-21 PSRO-22 PSRO-23 PSRO-24 PSRO-25

001 INITIAL BRIEF OFFICE VISIT	30.00	28.00	30.00	30.00	35.00	20.00	28.52*	22.82*	25.00	25.00	001
002 INITIAL LIMITED OFFICE VISIT						37.50	35.00	30.00	35.00	35.00	002
003 INIT INTERMED OFFICE VISIT						42.78*	60.00	50.00	49.91*	50.00	003
004 INIT COMP OFFICE VISIT	60.00	50.00	71.30*	65.00	71.30*	71.30*	71.30*	75.00	71.30*	71.30	004
005 MINIMAL F/U OFFICE VISIT	10.00	10.00	14.26*	8.00	14.26*	10.00	10.00*	8.00	10.00	11.20	005
006 BRIEF F/U OFFICE VISIT	14.26*	14.26*	14.26*	12.00	15.00	17.11*	14.26	15.00	15.00	20.00	006
007 LIMITED F/U OFFICE VISIT	16.00	17.11*	15.69*	16.00	20.00	20.00	21.39*	17.11*	20.00	21.39	007
008 INTERMED F/U OFFICE VISIT	20.00	21.39*	20.00	21.39*	20.00	25.00	21.39*	21.39*	20.00	25.00	008
009 EXTENDED F/U OFFICE VISIT	30.00	40.00	30.00	30.00	27.00	30.00	35.00	30.00	35.00	30.00	009
010 COMPLETE F/U OFFICE VISIT	50.00	49.91*	56.38	45.00	49.91*	57.04	64.17*	60.00	49.91*	49.91*	010
011 BRIEF F/U HOME VISIT	25.00	28.52*	15.00	20.00	25.00	25.00	25.53*	25.53*	20.00	25.53*	011
012 LIMITED F/U HOME VISIT						30.52*	20.00	30.00	30.00	30.00	012
013 INTERMEDIATE F/U HOME VISIT	30.00	30.00	25.00	28.52*	28.52*	34.31*	34.31*	25.00	30.00	34.31*	013
014 EXTENDED CARE FACILITY VISIT						17.25*	21.00	16.00	15.00	20.00	014
015 BRIEF F/U NURSING HOME VISIT	20.00*	20.00	21.10*	18.97*	25.00	25.95*	20.00	21.53*	21.53*	25.00	015
016 INITIAL BRIEF HOSPITAL VISIT	49.91*	49.91*	49.91*	35.00	48.00	40.00	49.91*	50.00	40.00	50.00	016
017 INIT INTERMED HOSPITAL VISIT						57.04*	71.30*	62.00	56.00	71.30*	017
018 INITIAL COMP HOSPITAL VISIT	71.30*	71.30*	71.30*	71.30*	74.87*	71.30*	71.30*	71.30*	74.87*	72.73*	018
019 BRIEF F/U HOSPITAL VISIT	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	019
020 LIMITED F/U HOSPITAL VISIT	20.00	25.00	21.39*	25.00	31.37*	21.39*	28.52*	21.39*	25.00	27.30	020
021 INTERMED F/U HOSPITAL VISIT	21.39*	21.39*	21.39*	28.52*	22.00*	21.39*	28.52*	21.39*	21.39*	28.52*	021
022 EXTENDED F/U HOSPITAL VISIT						28.52*	40.00	35.00	30.00	35.65*	022
023 BRIEF EMERGENCY ROOM VISIT						32.37*	32.37*	26.95*	24.29*	32.37*	023
024 LIMITED EMERGENCY ROOM VISIT						50.00	50.00	50.00	50.00	35.00	024
025 INTERMED EMERGENCY ROOM VISIT	37.50	35.65*	40.00	37.50	37.50*	52.00	49.91*	60.00	40.00	40.00	025
026 LIMITED CONSULTATION						55.00	71.30*	66.00	71.30	75.00	026
027 EXTENSIVE CONSULTATION						71.30	106.95*	100.00	100.00	106.95*	027
028 COMPREHENSIVE CONSULTATION						60.00	49.91*	60.00	57.04*	56.68*	028
029 PSYCHOTHERAPY-ONE HOUR						35.00	35.00	35.00	37.50	25.00	029
030 PSYCHOTHERAPY-HALF HOUR						12.69*	12.69*	11.12*	12.69*	12.69*	030
031 CHIROPRACTIC OFFICE VISIT	14.83*	15.83*	15.83*	15.00*	15.00*	12.00*	11.67*	12.00*	12.00	11.67*	031
032 INITIAL PHYSIOTHERAPY						17.00	17.11*	16.00	20.00	18.00	032
033 F/U PODIATRIC OFFICE VISIT						32.00	28.52*	28.52*	28.52*	28.52*	033
034 ELECTROCARDIOGRAM (EKG)	30.00	29.95*	30.00	28.52*	28.00	15.00*	14.62*	14.62*	20.00	15.00	034
035 EKG-INTERPRET REPORT ONLY	15.00	15.00	15.00	15.00	15.00	97.22*	72.93*	72.93*	72.93*	72.93*	035
036 ARTERIAL BLOOD GAS STUDY						75.00	75.00	70.00	65.00	75.00	036
037 ELECTROENCEPHALOGRAPH (EEG)						3.00	3.00	3.00	3.00	3.00	037
038 CHEMOTHERAPY						19.96*	19.96*	19.96	19.96*	19.96*	038
039 COLLECTION OF SPECIMENS						40.00	23.52*	42.78*	42.78*	45.00	039
040 DEBRIDEMENT OF NAILS						6.00	6.00	6.00	6.00	6.00	040
041 SKIN BIOPSY						1026.72*	1212.16*	1089.50*	1140.80*	1426.00*	041
042 CHEMOCAUTERY						1333.31*	1434.27*	1314.77*	1354.70*	1498.44*	042
043 RADICAL MASTECTOMY						28.52*	30.00	21.39*	28.52*	20.00*	043
044 OPEN REDUCTION OF FRACTURE						22.00	25.00	20.00	20.00	20.00	044
045 ARTHROCENTESIS-MAJOR JOINT						2000.00	2000.00	2000.00	2000.00	2000.00	045
046 ARTHROCENTESIS-MAJOR JOINT						25.00	25.00	25.00	21.96*	25.00	046
047 ARTHROPLASTY-REPAIR OF HIP						204.20*	210.00	192.51*	175.00	210.00*	047
048 ARTHROPLASTY-REPAIR OF HIP						49.91*	50.00	49.91*	50.00	50.00	048
049 ARTHROPLASTY-REPAIR OF HIP											049
050 ARTHROPLASTY-REPAIR OF HIP											050

1979 PREVAILING CHARGE SUMMARY DATA CALIFORNIA PHYSICIANS SERVICE

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-21	PSRO-22	PSRO-23	PSRO-24	PSRO-25	PSRO-21	PSRO-22	PSRO-23	PSRO-24	PSRO-25
051 CATHETERIZATION OF HEART						570.40*	570.40	520.00	570.40*	570.40*
052 INSERTION OF PACEMAKER						960.00*	1000.00*	891.25*	920.00*	891.25*
053 PARTIAL COLECTOMY						1296.00	1350.00	1320.00	1200.00	1500.00
054 APPENDECTOMY						513.36*	513.36*	513.36	570.40*	513.36*
055 SIGMOIDOSCOPY						38.50*	43.92*	43.92	39.50*	47.56*
056 HEMORRHOIDECTOMY	36.22*	36.31*	34.22*	31.02*	30.00	427.80*	427.80*	427.80	499.10*	450.00
057 CHOLECYSTECTOMY						941.16*	962.55*	855.60	1015.00	1015.00
058 REPAIR HERNIA						598.92*	641.70*	630.00	600.00*	713.00*
059 DIAGNOSTIC CYSTOURETHROSCOPY	70.00*	81.67*	72.93*	72.93*	82.64*	72.00	77.72*	71.30*	64.17*	85.00
060 DILATION OF URETHRA						21.39*	21.39*	26.00	21.39*	25.00
061 PROSTATECTOMY						1140.80*	1400.00	1176.45*	1140.80*	1500.00*
062 ELECTROSECTION-PROSTATE (TUR)	1205.60*	1409.76*	1312.53*	1458.37*	1458.37*	1140.80*	1283.40*	1140.80*	1140.80*	1311.92*
063 HYSTERECTOMY						1166.70*	998.20*	1026.72*	998.20*	1069.50*
064 INITIAL COMPLETE EYE EXAM						38.40	40.00	39.93*	40.00	40.00
065 COMPREHENSIVE EYE EXAM						40.00*	36.90*	45.00	39.93*	42.78*
066 EYE EXAM WITH TONOMETRY						12.83*	14.26*	17.11*	16.00	20.00
067 EXTRACTION OF LENS						998.20*	1234.49*	1140.80	1122.26*	1212.10*
068 CHEST X-RAY, SINGLE VIEW	972.25*	1263.92*	1156.99*	1166.70*	1215.31*	21.39*	21.39*	22.00	21.39*	24.24*
069 CHEST X-RAY, TWO VIEWS	20.00	20.00	20.00	20.00	24.24*	32.00	29.95*	30.00	29.95*	28.52*
070 X-RAY SPINE	30.00	31.37*	32.09*	30.00	30.00	62.00	64.88*	60.00	57.75*	57.04*
071 X-RAY HIP						38.00	34.22*	36.00	38.50*	35.65*
072 X-RAY UPPER GI TRACT	71.30	70.00	69.03*	60.00	70.00	69.00	65.67*	74.87*	76.29*	70.00
073 X-RAY COLON						65.00	64.17*	64.17*	68.00	70.00
074 RADIATION THERAPY-LOW VOLT	34.02*	34.02*	34.02*	38.89*	31.12*	35.00*	31.66*	31.66*	31.66*	31.66*
075 RADIATION THERAPY-SUPER VOLT	42.30*	42.30*	42.30*	42.30*	42.30*	42.78*	39.93*	42.78*	42.78*	39.93*
076 RADIATION THERAPY-MEGAVOLT						48.00	48.00	48.00	48.00	48.00
077 CAT SCAN - HEAD						225.00	225.00	225.00	225.00	225.00
078 CAT SCAN-HEAD, INTERPRET ONLY						90.00	90.00	90.00	90.00	90.00
079 THREE CHEMISTRY TESTS						20.00	22.00	21.00	20.00	26.00
080 TWELVE CHEMISTRY TESTS						26.25	40.00	25.50	25.00	30.00
081 CULTURE-OTHER THAN BLOOD						10.00	10.00	10.00	10.00	10.00
082 HEMOGLOBIN						4.40	5.00	5.00	5.00	6.00
083 AUTOKATED BLOOD COUNT						7.00	6.00	10.00	5.00	10.00
084 WHITE CELL COUNT						4.00	4.80	5.00	6.00	6.00
085 COMPLETE BLOOD COUNT (CBC)						10.00	11.00	11.00	9.90	10.60
086 CHOLESTEROL TEST						9.00	10.00	10.00	9.90	10.00
087 FLOCCULATION TEST						5.00	6.00	6.00	6.00	7.00
088 HEXATOCRIT						4.00	3.50	3.50	4.75	4.50
089 PLATELET COUNT (REES-ECKER)						8.00	7.00	8.00	8.00	10.00
090 POTASSIUM TEST						9.00	11.00	10.00	7.00	10.00
091 PROTHROMBIN						8.00	8.00	8.00	8.00	9.00
092 SEDIMENTATION RATE						7.00	7.00	7.50	5.10	7.00
093 BLOOD SUGAR						8.00	10.00	10.00	8.00	10.00
094 BUN-UREA, NITROGEN						8.50	10.00	10.00	8.00	10.00
095 URIC ACID						9.00	10.50	10.00	8.00	9.00
096 FECES-OCCULT BLOOD						5.50	6.00	6.00	7.00	6.00
097 PAP TEST						10.00	11.00	15.00	15.00	12.00
098 ROUTINE URINALYSIS						6.00	7.00	7.00	6.00	7.00
099 CHEMICAL URINALYSIS						4.00	3.00	5.00	4.00	6.00
100 PATHOLOGY-THREE SPECIMENS						22.00	25.00	20.00	25.00	25.00

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA

CALIFORNIA PHYSICIANS SERVICE
LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-26	PSRO-27	PSRO-28	PSRO-26	PSRO-27	PSRO-28
001 INITIAL BRIEF OFFICE VISIT	25.00	28.00	28.00	25.00	22.82*	20.00
002 INITIAL LIMITED OFFICE VISIT				30.00	30.00	25.00
003 INIT INTERMED OFFICE VISIT				49.91*	55.00	49.91*
004 INIT COMP OFFICE VISIT	71.30*	50.00	68.45*	71.30*	71.30*	70.00
005 MINIMAL F/U OFFICE VISIT	11.41*	11.41*	9.98*	9.00	8.00	8.50
006 BRIEF F/U OFFICE VISIT	14.26*	11.41*	12.83*	17.11*	14.00	13.00
007 LIMITED F/U OFFICE VISIT	17.11*	15.69*	15.60	17.11*	18.00	15.69*
008 INTERMED F/U OFFICE VISIT	20.00	20.00	21.00	21.39*	21.39*	23.00
009 EXTENDED F/U OFFICE VISIT	25.00	25.00	37.00	25.00	30.00	35.00
010 COMPLETE F/U OFFICE VISIT	49.91*	45.00	49.91*	57.04*	57.04*	55.00
011 BRIEF F/U HOME VISIT	23.52*	21.39*	22.82*	25.53*	25.53*	25.00
012 LIMITED F/U HOME VISIT				30.00	30.52*	35.00
013 INTERMEDIATE F/U HOME VISIT	28.52*	29.95*	35.00	30.00	34.31*	34.31*
014 EXTENDED CARE FACILITY VISIT				20.00	16.26*	16.00
015 BRIEF F/U NURSING HOME VISIT	21.10*	20.00	18.97*	21.00	16.00	17.25*
016 INITIAL BRIEF HOSPITAL VISIT	49.91*	35.65*	38.50*	50.00	45.00	35.65*
017 INIT INTERMED HOSPITAL VISIT				71.30*	57.04*	56.00
018 INITIAL COMP HOSPITAL VISIT	71.30*	68.45*	68.45*	71.30*	71.30*	78.75
019 BRIEF F/U HOSPITAL VISIT	18.54*	14.26*	14.26*	20.00	16.00	15.00
020 LIMITED F/U HOSPITAL VISIT	21.39	20.00	20.00	22.82*	21.39*	22.50
021 INTERMED F/U HOSPITAL VISIT	25.00	25.00*	18.00*	21.39*	25.00*	21.39*
022 EXTENDED F/U HOSPITAL VISIT				35.00	30.00	35.65*
023 BRIEF EMERGENCY ROOM VISIT				26.95*	16.51*	24.29*
024 LIMITED EMERGENCY ROOM VISIT				32.37*	35.50	31.80*
025 LIMITED EMERGENCY ROOM VISIT				49.91*	40.00	50.00
026 LIMITED CONSULTATION	37.50	35.65*	40.00	50.00	35.65*	42.78*
027 EXTENSIVE CONSULTATION				71.30*	60.00	59.18*
028 COMPREHENSIVE CONSULTATION				85.56*	71.30*	84.13*
029 PSYCHOTHERAPY-ONE HOUR				57.04*	65.00	57.04*
030 PSYCHOTHERAPY-HALF HOUR				34.22*	40.00	34.22*
031 CHIROPRACTIC OFFICE VISIT	18.53*	13.69*	15.83*	12.69*	10.55*	12.69*
032 INITIAL PHYSIOTHERAPY				11.67*	11.67*	11.67*
033 F/U PODIATRIC OFFICE VISIT				16.00	15.00	15.00
034 ELECTROCARDIOGRAM (EKG)	30.00	27.00	30.00	28.52*	29.50	28.00
035 EKG-INTERPRET, REPORT ONLY	15.00	15.00	20.00	15.00*	14.26*	13.00
036 ARTERIAL BLOOD GAS STUDY				72.93*	72.93*	81.57*
037 ELECTROENCEPHALOGRAPH (EEG)				71.30*	81.28*	71.30*
038 CHEMOTHERAPY						
039 COLLECTION OF SPECIMENS				3.00	3.00	3.00
040 DEBRIDEMENT OF NAILS				19.96*	19.96*	19.96*
041 SKIN BIOPSY				40.00	36.36*	40.00
042 CHEMOCAUTERY				6.00	6.00	6.00
043 RADICAL MASTECTOMY				1126.54*	1026.72*	1026.72*
044 OPEN REDUCTION OF FRACTURE				1314.77*	1195.27*	1254.88*
045 ARTHROCENTESIS-MAJOR JOINT				28.52*	28.52*	29.95*
046 ARTHROTOMY				20.00	20.00	20.00
047 ARTHROPLASTY-REPAIR OF HIP	20.00	20.00	24.00	2000.00	2000.00	2000.00
048 NEEDLE PUNCTURE OF BURSA				25.00	25.00	21.68*
049 BRONCHOSCOPY				192.51*	179.68*	192.51*
050 THORACENTESIS				49.91*	45.00	45.00

1979 PREVAILING CHARGE SUMMARY DATA CALIFORNIA PHYSICIANS SERVICE

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-26	PSRO-27	PSRO-28	PSRO-26	PSRO-27	PSRO-28	
051 CATHETERIZATION OF HEART				570.40*	570.40*	550.00	051
052 INSERTION OF PACEMAKER				960.00*	891.25*	974.00*	052
053 PARTIAL COLECTOMY				1197.84*	1026.72*	1026.72*	053
054 APPENDECTOMY				513.36*	513.36*	501.24*	054
055 SIGMOIDOSCOPY	34.22*	30.00*	34.22*	36.22*	38.50*	32.94*	055
056 HEMORRHOIDECTOMY				427.80*	427.80*	385.02*	056
057 CHOLECYSTECTOMY				827.08	855.60*	827.08*	057
058 REPAIR HERNIA				513.36*	484.84*	523.34*	058
059 DIAGNOSTIC CYSTOURETHROSCOPY	73.90*	72.93*	63.20*	66.59*	59.89*	61.03*	059
060 DILATION OF URETHRA				1112.28*	25.00	21.39*	060
061 PROSTATECTOMY				1140.80*	1140.80*	1120.00	061
062 ELECTROSECTION-PROSTATE (TUR)	1174.48*	1166.70*	1118.08*	1112.28*	998.20*	1026.72*	062
063 HYSTERECTOMY				998.20*	962.55*	926.90*	063
064 INITIAL COMPLETE EYE EXAM				35.00	36.00	33.60	064
065 COMPREHENSIVE EYE EXAM				34.22*	40.00*	35.00*	065
066 EYE EXAM WITH TONOMETRY				14.26	15.68*	15.00	066
067 EXTRACTION OF LENS	972.25*	972.25*	923.63*	953.99	926.90*	950.00	067
068 CHEST X-RAY-SINGLE VIEW	20.00	19.96*	20.00	20.50	18.00	21.39*	068
069 CHEST X-RAY-TWO VIEWS	31.00	27.00	29.95*	30.00	27.81*	29.50	069
070 X-RAY SPINE				59.18*	64.00	60.00	070
071 X-RAY HIP				35.00	31.37*	34.94*	071
072 X-RAY UPPER GI TRACT	69.87*	70.00	70.00	69.16	64.17*	66.00	072
073 X-RAY COLON				64.17	57.00	64.17*	073
074 RADIATION THERAPY-LOW VOLT	29.16*	41.81*	29.16*	31.66*	31.66*	31.66*	074
075 RADIATION THERAPY-SUPER VOLT	42.30*	42.30*	48.61*	39.93*	45.63*	39.93*	075
076 RADIATION THERAPY-MEGAVOLT				48.00	48.00	48.00	076
077 CAT SCAN - HEAD				225.00	225.00	225.00	077
078 CAT SCAN-HEAD-INTERPRET ONLY				90.00	90.00	90.00	078
079 THREE CHEMISTRY TESTS				25.00	21.50	20.00	079
080 TWELVE CHEMISTRY TESTS				25.00	25.00	20.60	080
081 CULTURE-OTHER THAN BLOOD				8.00	10.00	10.00	081
082 HEMOGLOBIN				5.00	4.00	4.80	082
083 AUTOMATED BLOOD COUNT				7.00	6.00	6.90	083
084 WHITE CELL COUNT				5.00	2.00	4.00	084
085 COMPLETE BLOOD COUNT (CBC)				10.00	10.00	10.00	085
086 CHOLESTEROL TEST				8.00	8.50	8.80	086
087 FLOCCULATION TEST				5.00	7.00	7.40	087
088 HEMATOCRIT				5.00	4.00	5.00	088
089 PLATELET COUNT (REES-ECKER)				8.00	6.50	8.40	089
090 POTASSIUM TEST				8.50	8.50	8.50	090
091 PROTHROMBIN				7.00	7.00	7.40	091
092 SEDIMENTATION RATE				6.00	7.00	6.00	092
093 BLOOD SUGAR				8.00	8.25	8.75	093
094 BUN-UREA-NITROGEN				9.00	9.00	8.50	094
095 URIC ACID				9.00	8.50	8.50	095
096 FECES-OCCULT BLOOD				6.00	6.00	6.00	096
097 PAP TEST				15.00	10.00	9.50	097
098 ROUTINE URINALYSIS				6.00	6.00	6.00	098
099 CHEMICAL URINALYSIS				5.00	3.00	4.80	099
100 PATHOLOGY-THREE SPECIMENS				20.00	25.00	21.40	100

1979 PREVAILING CHARGE SUMMARY DATA OCCIDENTAL LIFE INSURANCE CO.

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-15	PSRO-16	PSRO-17	PSRO-18	PSRO-19	PSRO-15	PSRO-16	PSRO-17	PSRO-18	PSRO-19
001 INITIAL BRIEF OFFICE VISIT	30.00	25.00	24.00	30.00	27.00	25.00	22.00	18.00	25.00	25.00
002 INITIAL LIMITED OFFICE VISIT						35.00	30.00	30.00	35.00	35.00
003 INIT INTERMED OFFICE VISIT						49.90*	50.00	57.00*	57.00*	42.80*
004 INIT COMP OFFICE VISIT	70.00	53.00	60.00	70.00	64.20*	70.00	71.30*	74.20*	71.30*	71.30*
005 MINIMAL F/U OFFICE VISIT	10.00	10.00*	8.00	9.00	10.00	10.00*	9.00	9.10*	10.00	10.00
006 BRIEF F/U OFFICE VISIT	11.40*	12.10*	11.40*	14.30*	14.30*	15.00*	14.30*	17.10*	17.80*	17.10*
007 LIMITED F/U OFFICE VISIT	15.00	15.00	15.00	17.80*	17.10*	15.70*	17.80*	18.50*	20.00	17.10*
008 INTERMED F/U OFFICE VISIT	20.00	20.00	17.00	20.00	20.00	19.00	20.00	24.00	21.40*	20.00
009 EXTENDED F/U OFFICE VISIT	36.00	25.00	28.00	30.00	30.00	42.80*	33.00	20.00	30.00	35.00
010 COMPLETE F/U OFFICE VISIT	49.90*	49.90*	48.50*	62.50	49.90*	49.90*	53.50*	48.50*	57.00*	65.00
011 BRIEF F/U HOME VISIT	21.40*	20.00	20.00	28.50*	25.00	25.50*	25.50*	25.50*	20.00	25.00
012 LIMITED F/U HOME VISIT						30.00	30.00	30.00	30.00	30.50*
013 INTERMEDIATE F/U HOME VISIT	25.00	30.00*	28.50*	28.50*	35.00	34.30	34.30	34.30	30.00	34.30
014 EXTENDED CARE FACILITY VISIT						17.25*	15.00	14.00	20.00	18.90*
015 BRIEF F/U NURSING HOME VISIT	17.00*	19.00*	20.00	20.00	21.10*	20.00	17.25*	20.00	21.50*	21.10*
016 INITIAL BRIEF HOSPITAL VISIT	35.70*	36.40*	35.70*	49.90*	40.00	35.70*	38.50*	35.70*	49.90*	49.90*
017 INIT INTERMED HOSPITAL VISIT						50.00	57.00*	57.00*	65.00	64.20*
018 INITIAL COMP HOSPITAL VISIT	71.30*	60.00	68.50*	75.00	71.30*	75.00	71.30*	75.00	71.30*	71.30*
019 BRIEF F/U HOSPITAL VISIT	14.30*	14.30*	14.30*	20.00	17.10*	15.00	14.30*	15.00	20.00	20.00
020 LIMITED F/U HOSPITAL VISIT	20.00*	18.00	20.00	20.00	20.00	20.00*	21.40*	22.00	21.40*	22.80*
021 INTERMED F/U HOSPITAL VISIT	28.50*	25.00	21.40*	21.40*	16.00	21.40*	21.40*	26.30	21.40*	21.40*
022 EXTENDED F/U HOSPITAL VISIT						35.70*	33.00	45.00	35.00	30.00
023 BRIEF EMERGENCY ROOM VISIT						21.50*	21.50*	20.00	27.00*	27.00*
024 LIMITED EMERGENCY ROOM VISIT						32.40*	29.20	32.40*	29.10*	35.70*
025 INTERMED EMERGENCY ROOM VISIT						50.00	50.00	50.00	50.00	50.00
026 LIMITED CONSULTATION	35.70*	35.70*	37.50	37.50	37.50	40.00	38.50*	49.90*	40.00	57.00*
027 EXTENSIVE CONSULTATION						53.50*	64.20*	57.00*	60.00	60.00
028 COMPREHENSIVE CONSULTATION						85.00	78.40*	81.30*	100.00	85.60*
029 PSYCHOTHERAPY-ONE HOUR						50.00	49.90*	50.00	60.00	50.00
030 PSYCHOTHERAPY-HALF HOUR						30.00	35.00	30.00	30.00	35.70*
031 CHIROPRACTIC OFFICE VISIT	15.80*	15.00	21.10*	12.70*	12.70*	10.60*	10.60	12.70*	12.70*	12.70*
032 INITIAL PHYSIOTHERAPY						12.00	11.70	12.00	11.70	11.70
033 F/U PODIATRIC OFFICE VISIT						14.00	18.00	15.00	20.00	18.00
034 ELECTROCARDIOGRAM (EKG)	30.00*	28.00	32.00	30.00*	30.00*	28.00	30.00	30.00	28.50*	30.00
035 EKG-INTERPRET, REPORT ONLY	15.00	15.00	15.00	15.00	15.00	15.00	13.50	15.00	15.00	14.30*
036 ARTERIAL BLOOD GAS STUDY						72.93*	72.93	72.93	72.93*	72.93
037 ELECTROENCEPHALOGRAM (EEG)						75.00	75.00	70.00	90.00	80.00
038 CHEMOTHERAPY										
039 COLLECTION OF SPECIMENS						5.00	5.00	5.00	5.00	5.00
040 DEBRIDEMENT OF NAILS						20.00*	20.00*	20.00*	25.00	20.00*
041 SKIN BIOPSY						36.40*	36.40*	36.40*	45.00	30.00
042 CHEMOCAUTERY						22.80*	22.80*	22.80*	25.00	19.00
043 RADICAL MASTECTOMY						855.60*	1083.80*	1026.70*	1212.10*	1078.10*
044 OPEN REDUCTION OF FRACTURE						1140.80*	1098.00*	1195.30*	1283.40*	1314.80*
045 ARTHROCENTESIS-MAJOR JOINT						28.50*	28.50*	28.00	30.00	25.00
046 ARTHROTOMY						20.00	20.00	20.00	20.00	25.00
047 ARTHROPLASTY-REPAIR OF HIP						2000.00	2000.00	2000.00	2000.00	2000.00
048 NEEDLE PUNCTURE OF BURSA						25.00	25.00	25.00	25.00	17.50
049 BRONCHOSCOPY						192.50*	192.50*	192.50*	192.50*	192.50*
050 THORACENTESIS						49.90*	49.90*	49.90*	49.90*	49.90*

1979 PREVAILING CHARGE SUMMARY DATA OCCIDENTAL LIFE INSURANCE CO.

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-15	PSRO-16	PSRO-17	PSRO-18	PSRO-19	PSRO-15	PSRO-16	PSRO-17	PSRO-18	PSRO-19
051 CATHETERIZATION OF HEART						550.00	570.40*	520.00	570.40*	570.40*
052 INSERTION OF PACEMAKER						891.25*	960.00	1000.00	1000.00	891.25*
053 PARTIAL COLECTOMY						912.60*	1040.00	969.70*	1140.80*	1098.00*
054 APPENDECTOMY						450.30*	513.40*	513.40*	513.40*	513.40*
055 SIGMOIDOSCOPY	31.90*	31.00*	35.70*	36.30	36.20*	38.50*	34.20*	38.50*	36.70*	35.90*
056 HEMORRHOIDECTOMY						396.00	427.80*	427.80*	427.80*	427.80*
057 CHOLECYSTECTOMY						752.90*	820.00	784.30*	916.90*	855.60*
058 REPAIR HERNIA						474.90*	539.00*	539.00*	570.40*	570.40*
059 DIAGNOSTIC CYSTOURETHROSCOPY	72.93*	67.66*	70.00*	75.83	58.34*	57.00*	59.90*	61.00*	71.30*	60.00
060 DILATION OF URETHRA						22.80*	24.20*	21.00	22.80*	30.00
061 PROSTATECTOMY						1100.00	1140.80*	1140.80*	1188.60*	1197.80*
062 ELECTROSECTION-PROSTATE (TUR)	1118.08*	1166.70*	1166.70*	1263.92	1166.70*	959.70*	1140.80*	912.60*	1212.10*	1197.80*
063 HYSTERECTOMY						962.60*	962.60*	962.60*	998.20*	1050.00
064 INITIAL COMPLETE EYE EXAM						30.40	35.00	34.00	36.00	37.40*
065 COMPREHENSIVE EYE EXAM						30.00*	40.00	34.22*	42.78*	37.08*
066 EYE EXAM WITH TONOMETRY						15.00*	14.30*	15.00*	15.00	15.00
067 EXTRACTION OF LENS						864.20*	950.00	998.20*	1100.00	1140.80*
068 CHEST X-RAY-SINGLE VIEW	855.59*	923.63*	1166.70*	1069.47	1069.47*	18.00	20.00	21.40*	22.00	22.00
069 CHEST X-RAY-TWO VIEWS	22.80*	21.40*	22.80*	22.00	21.40*	28.00	30.00*	32.10*	27.00	32.10*
070 X-RAY SPINE	28.00	30.00*	36.00	30.00*	30.00*	55.60*	60.00	69.50*	60.00	65.00
071 X-RAY HIP						32.00	35.00	37.50*	30.00	37.50*
072 X-RAY UPPER GI TRACT	70.00	70.00	70.00	70.00	70.00	64.20*	69.90*	71.00	66.00	71.00
073 X-RAY COLON						51.30*	64.20*	64.20*	60.00	68.00
074 RADIATION THERAPY-LOW VOLT						31.70*	31.70*	31.70*	31.70*	31.70*
075 RADIATION THERAPY-SUPER VOLT		26.25*	34.02	34.02	34.02*	39.90*	39.90*	42.80*	39.90*	42.80*
076 RADIATION THERAPY-MEGAVOLT		42.30*	42.30*	42.30	42.30*	48.00	48.00	48.00	48.00	48.00
077 CAT SCAN - HEAD						225.00	225.00	225.00	225.00	225.00
078 CAT SCAN-HEAD,INTERPRET ONLY						90.00	90.00	90.00	90.00	90.00
079 THREE CHEMISTRY TESTS						20.00	22.00	15.90	20.50	22.50
080 TWELVE CHEMISTRY TESTS						19.50	22.50	25.00	20.00	24.00
081 CULTURE-OTHER THAN BLOOD						7.50	10.75	10.00	10.00	8.50
082 HEMOGLOBIN						5.00	5.00	4.00	4.00	5.00
083 AUTOMATED BLOOD COUNT						6.50	5.50	7.00	9.00	4.00
084 WHITE CELL COUNT						4.50	5.00	7.00	3.00	5.00
085 COMPLETE BLOOD COUNT (CBC)						10.50	13.25	10.00	9.50	10.00
086 CHOLESTEROL TEST						8.50	9.50	9.00	8.00	9.00
087 FLOCCULATION TEST						7.00	9.50	6.70	4.00	10.00
088 HEMATOCRIT						5.00	5.00	4.00	4.50	5.00
089 PLATELET COUNT (REES-ECKER)						8.00	7.50	10.00	5.00	10.50
090 POTASSIUM TEST						8.00	13.25	8.40	8.40	9.50
091 PROTHROMBIN						7.00	8.00	8.00	6.50	7.00
092 SEDIMENTATION RATE						6.00	7.20	6.00	6.00	6.00
093 BLOOD SUGAR						8.00	11.00	9.00	8.50	10.00
094 BUN-UREA,NITROGEN						9.00	9.00	8.40	8.00	9.00
095 URIC ACID						8.50	10.00	9.00	8.50	9.00
096 FECES-OCCULT BLOOD						6.00	5.00	6.00	6.00	5.00
097 PAP TEST						10.00	10.00	10.00	12.50	10.00
098 ROUTINE URINALYSIS						6.00	6.50	6.00	6.00	6.00
099 CHEMICAL URINALYSIS						3.50	6.00	4.00	5.00	4.00
100 PATHOLOGY-THREE SPECIMENS						24.00	35.00	22.00	20.00	26.00

1979 PREVAILING CHARGE SUMMARY DATA

CALIFORNIA

OCCIDENTAL LIFE INSURANCE CO.

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-20	PSRO-21	PSRO-22	PSRO-23	PSRO-24	PSRO-20	PSRO-21	PSRO-22	PSRO-23	PSRO-24
001 INITIAL BRIEF OFFICE VISIT	29.00	30.00	28.00	30.00	30.00	25.00	20.00	28.50*	22.80*	25.00
002 INITIAL LIMITED OFFICE VISIT						30.00	37.50	35.00	30.00	35.00
003 INIT INTERMED OFFICE VISIT						49.90*	42.80*	60.00	50.00	49.90*
004 INIT COMP OFFICE VISIT	75.00	60.00	50.00	71.30*	65.00	71.30*	71.30*	71.30*	75.00	71.30*
005 MINIMAL F/U OFFICE VISIT	10.00	10.00	10.00	14.30*	8.00	10.00	10.00	10.00*	8.00	10.00
006 BRIEF F/U OFFICE VISIT	14.30*	14.30*	14.30*	14.30*	12.00	17.10	17.10*	14.26*	15.00	15.00
007 LIMITED F/U OFFICE VISIT	17.10*	16.00	17.10*	15.70*	16.00	20.00	20.00	21.40*	17.10*	20.00
008 INTERMED F/U OFFICE VISIT	20.00	20.00	21.40*	20.00	21.40*	22.00	25.00	21.40*	21.40*	20.00
009 EXTENDED F/U OFFICE VISIT	30.00	30.00	40.00	30.00	30.00	25.00	30.00	35.00	30.00	35.00
010 COMPLETE F/U OFFICE VISIT	49.90*	50.00	49.90*	60.00	45.00	59.20*	56.38*	64.20*	60.00	49.90*
011 BRIEF F/U HOME VISIT	28.50*	25.00	28.50*	15.00	20.00	25.50*	25.00	25.50*	25.50*	20.00
012 LIMITED F/U HOME VISIT						30.00	30.50	20.00	30.00	30.00
013 INTERMEDIATE F/U HOME VISIT	28.50*	30.00	30.00	25.00	28.50*	25.00	34.30	34.30	25.00	30.00
014 EXTENDED CARE FACILITY VISIT						21.00	17.25*	21.00	16.00	15.00
015 BRIEF F/U NURSING HOME VISIT	21.10*	20.00	20.00	21.10*	19.00*	21.50*	26.00*	20.00	21.50*	21.50*
016 INITIAL BRIEF HOSPITAL VISIT	49.90*	49.90*	49.90*	49.90*	35.00	49.90*	40.00	49.90*	50.00	40.00
017 INIT INTERMED HOSPITAL VISIT						68.50*	57.00*	71.30*	62.00	56.00
018 INITIAL COMP HOSPITAL VISIT	75.00	71.30*	71.30*	71.30*	71.30*	71.30*	71.30*	71.30*	71.30*	74.90*
019 BRIEF F/U HOSPITAL VISIT	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00
020 LIMITED F/U HOSPITAL VISIT	22.80*	20.00	25.00	21.40*	25.00	25.00	21.40*	28.50*	21.40*	25.00
021 INTERMED F/U HOSPITAL VISIT	25.00	21.40*	21.40*	21.40*	28.50*	25.00	21.40	28.50*	21.40*	21.40*
022 EXTENDED F/U HOSPITAL VISIT						28.50*	28.50	40.00	35.00	30.00
023 BRIEF EMERGENCY ROOM VISIT						27.00*	26.00	27.00	27.00*	24.30
024 LIMITED EMERGENCY ROOM VISIT						50.00	50.00	50.00	50.00	50.00
025 INTERMED EMERGENCY ROOM VISIT	37.50	37.50	35.70*	40.00	37.50	43.00	52.00	49.90*	60.00	40.00
026 LIMITED CONSULTATION						71.30*	55.00	71.30*	66.00	71.39*
027 EXTENSIVE CONSULTATION						92.70*	71.30*	107.00*	100.00	100.00
028 COMPREHENSIVE CONSULTATION						57.00*	60.00	49.90*	60.00	57.00*
029 PSYCHOTHERAPY-ONE HOUR						35.70*	35.00	35.00	35.00	37.50
030 PSYCHOTHERAPY-HALF HOUR						12.70*	12.70*	12.70*	11.10*	12.70*
031 CHIROPRACTIC OFFICE VISIT	17.10	14.80*	15.80*	15.80*	15.00	11.70	12.00	11.70	12.00	12.00
032 INITIAL PHYSIOTHERAPY						18.00	17.00	17.10*	16.00	20.00
033 F/U PODIATRIC OFFICE VISIT	30.00*	30.00	30.00*	30.00	28.50*	30.00	30.00*	28.50*	28.50*	28.50*
034 ELECTROCARDIOGRAM (EKG)	15.00	15.00	15.00	15.00	15.00	14.30*	18.00	14.60	14.60	20.00
035 EKG-INTERPRET-REPORT ONLY						97.22*	72.93*	72.93*	72.93*	72.93*
036 ARTERIAL BLOOD GAS STUDY						65.00	75.00	85.00	70.00	65.00
037 ELECTROENCEPHALOGRAPH (EEG)						5.00	5.00	5.00	5.00	5.00
038 CHEMOTHERAPY						24.50	20.00*	20.00*	20.00*	20.00*
039 COLLECTION OF SPECIMENS						36.40*	40.00	36.40*	42.80*	42.80*
040 DEBRIDEMENT OF NAILS						22.80*	22.80*	25.00	22.00	25.00
041 SKIN BIOPSY						1069.50*	1026.70*	1212.10	1069.50*	1140.80*
042 CHEMOCAUTERY						1303.90*	1333.30*	1434.30*	1314.80*	1354.70*
043 RADICAL MASTECTOMY						28.50*	28.50*	30.00	21.40*	28.50*
044 OPEN REDUCTION OF FRACTURE						20.00	22.00	25.00	20.00	20.00
045 ARTHROCENTESIS-MAJOR JOINT						2000.00	2000.00	2000.00	2000.00	2000.00
046 ARTHROTOMY						22.00	25.00	25.00	25.00	22.00
047 ARTHROPLASTY-REPAIR OF HIP	20.00	20.00	20.00	28.50*	20.00	225.00	204.20	210.00	192.50*	175.00
048 NEEDLE PUNCTURE OF BURSA						50.00	49.90*	50.00	49.90*	50.00
049 BRONCHOSCOPY										
050 THORACENTESIS										

1979 PREVAILING CHARGE SUMMARY DATA OCCIDENTAL LIFE INSURANCE CO.

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-20	PSRO-21	PSRO-22	PSRO-23	PSRO-24	PSRO-20	PSRO-21	PSRO-22	PSRO-23	PSRO-24
051 CATHETERIZATION OF HEART						550.00	570.40*	570.40*	520.00	570.40*
052 INSERTION OF PACEMAKER						891.25	960.00	1000.00	891.25*	920.00
053 PARTIAL COLECTOMY						1250.00	1296.00	1350.00	1320.00	1200.00
054 APPENDECTOMY						513.40*	513.40*	513.40*	513.40*	570.40*
055 SIGMOIDOSCOPY	36.20*	36.20*	36.30	34.20*	31.00*	39.50*	38.50*	43.90*	43.90*	39.50*
056 HEMORRHOIDECTOMY						427.80*	427.80*	427.80*	427.80*	499.10*
057 CHOLECYSTECTOMY						926.90*	941.20*	962.60*	855.60*	1015.00
058 REPAIR HERNIA						570.40*	598.90*	641.70*	630.00	600.00
059 DIAGNOSTIC CYSTOURETHROSCOPY	72.93*	70.00*	81.67*	72.93*	72.93*	71.30*	72.00	77.70*	71.30*	64.20*
060 DILATION OF URETHRA						24.20*	21.40*	21.40*	26.00	21.40*
061 PROSTATECTOMY						1180.00*	1140.80*	1400.00	1176.50*	1140.80*
062 ELECTROSECTION-PROSTATE (TUR)	1458.37*	1205.60*	1409.76*	1312.53*	1458.37*	1180.00*	1140.80*	1283.40*	1140.80*	1140.80*
063 HYSTERECTOMY						1200.00	1201.00	998.20*	1026.70*	998.20*
064 INITIAL COMPLETE EYE EXAM						38.40	38.40	40.00	39.90*	40.00
065 COMPREHENSIVE EYE EXAM						34.22	40.00*	36.90*	45.00	31.93*
066 EYE EXAM WITH TONOMETRY						14.30*	12.80*	14.30*	17.10*	16.00
067 EXTRACTION OF LENS						1234.50*	998.20*	1234.50*	1140.80*	1122.30*
068 CHEST X-RAY, SINGLE VIEW	1263.92*	972.25*	1263.92*	1156.99*	1166.70*	22.00	21.40*	21.40*	22.00	21.40*
069 CHEST X-RAY, TWO VIEWS	30.00*	30.00	31.40*	32.10*	30.00	30.00	32.00	30.00	30.00	30.00*
070 X-RAY SPINE						60.00	62.00	64.90*	60.00	57.75*
071 X-RAY HIP						33.00	38.00	34.20*	36.00	38.50*
072 X-RAY UPPER GI TRACT	70.00	71.30*	70.00	64.20*	60.00	72.00*	69.00	65.70	74.90*	76.30*
073 X-RAY COLON						67.00	65.00	64.20*	64.20*	68.00
074 RADIATION THERAPY-LOW VOLT	43.75*	34.02*	34.02*	34.02*	38.89*	31.70*	35.00	31.70*	31.70*	31.70*
075 RADIATION THERAPY-SUPER VOLT	42.30*	42.30*	42.30*	42.30*	42.30*	39.90*	42.80	39.90*	42.80*	42.80*
076 RADIATION THERAPY-MEGAVOLT						48.00	48.00	48.00	48.00	48.00
077 CAT SCAN - HEAD						225.00	225.00	225.00	225.00	225.00
078 CAT SCAN-HEAD, INTERPRET ONLY						90.00	90.00	90.00	90.00	90.00
079 THREE CHEMISTRY TESTS						15.00	20.00	22.00	21.00	20.00
080 TWELVE CHEMISTRY TESTS						20.00	26.25	40.00	25.50	25.00
081 CULTURE-OTHER THAN BLOOD						10.00	10.00	10.00	10.00	10.00
082 HEMOGLOBIN						5.00	4.40	5.00	5.00	5.00
083 AUTOMATED BLOOD COUNT						6.00	7.00	6.00	10.00	5.00
084 WHITE CELL COUNT						5.50	4.00	4.90	5.00	6.00
085 COMPLETE BLOOD COUNT (CBC)						10.00	10.00	11.00	11.00	9.90
086 CHOLESTEROL TEST						9.00	9.00	10.00	10.00	9.90
087 FLOCCULATION TEST						8.50	5.00	6.00	6.00	6.00
088 HEMATOCRIT						5.00	4.00	3.50	3.50	4.75
089 PLATELET COUNT (REES-ECKER)						7.40	8.00	7.00	8.00	8.00
090 POTASSIUM TEST						8.40	9.00	11.00	10.00	7.00
091 PROTHROMBIN						8.00	8.00	8.00	8.00	8.00
092 SEDIMENTATION RATE						6.00	7.00	7.00	7.50	5.10
093 BLOOD SUGAR						8.40	8.00	10.00	10.00	8.00
094 BUN-UREA NITROGEN						9.00	8.50	10.00	10.00	8.00
095 URIC ACID						8.50	9.00	10.50	10.00	8.00
096 FECES-OCCULT BLOOD						7.00	5.50	6.00	6.00	7.00
097 PAP TEST						10.00	10.00	11.00	15.00	15.00
098 ROUTINE URINALYSIS						6.00	6.00	7.00	7.00	6.00
099 CHEMICAL URINALYSIS						5.00	4.00	3.00	5.00	4.00
100 PATHOLOGY-THREE SPECIMENS						25.00	22.00	25.00	20.00	25.00

1979 PREVAILING CHARGE SUMMARY DATA

OCCIDENTAL LIFE INSURANCE CO.

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

PSRO-25 PSRO-26 PSRO-27 PSRO-28

PSRO-25 PSRO-26 PSRO-27 PSRO-28

001 INITIAL BRIEF OFFICE VISIT	35.00	25.00	22.80*	20.00	001
002 INITIAL LIMITED OFFICE VISIT		35.00	30.00	25.00	002
003 INIT INTERMED OFFICE VISIT		50.00	49.90*	49.90*	003
004 INIT COMP OFFICE VISIT	71.30*	71.30*	71.30*	70.00	004
005 MINIMAL F/U OFFICE VISIT	14.30*	11.40*	11.20	8.50	005
006 BRIEF F/U OFFICE VISIT	15.00	14.30*	17.10*	13.00	006
007 LIMITED F/U OFFICE VISIT	20.00	17.10*	17.10*	15.70*	007
008 INTERMED F/U OFFICE VISIT	20.00	20.00	21.40*	23.00	008
009 EXTENDED F/U OFFICE VISIT	27.00	25.00	30.00	35.00	009
010 COMPLETE F/U OFFICE VISIT	49.90*	49.90*	57.00*	55.00	010
011 BRIEF F/U HOME VISIT	25.00	25.50*	25.50*	25.00	011
012 LIMITED F/U HOME VISIT		30.00	30.50*	35.00	012
013 INTERMEDIATE F/U HOME VISIT	28.50*	34.30	34.30	34.30	013
014 EXTENDED CARE FACILITY VISIT		20.00	16.30*	16.00	014
015 BRIEF F/U NURSING HOME VISIT	25.00	25.00	16.00	17.25*	015
016 INITIAL BRIEF HOSPITAL VISIT	48.00	50.00	45.00	35.70*	016
017 INIT INTERMED HOSPITAL VISIT		71.30*	57.00*	56.00	017
018 INITIAL COMP HOSPITAL VISIT	74.90*	72.70*	71.30*	78.75	018
019 BRIEF F/U HOSPITAL VISIT	20.00	20.00	16.00	15.00	019
020 LIMITED F/U HOSPITAL VISIT	31.40*	27.30	21.40*	22.50	020
021 INTERMED F/U HOSPITAL VISIT	22.00	28.50*	25.00	21.40*	021
022 EXTENDED F/U HOSPITAL VISIT		35.70*	30.00	35.70*	022
023 BRIEF EMERGENCY ROOM VISIT		32.40*	16.50	24.30	023
024 LIMITED EMERGENCY ROOM VISIT		35.00	35.50	31.80*	024
025 INTERMED EMERGENCY ROOM VISIT		35.00	40.00	50.00	025
026 LIMITED CONSULTATION	37.50	35.70*	35.70*	42.80*	026
027 EXTENSIVE CONSULTATION		75.00	60.00	59.20*	027
028 COMPREHENSIVE CONSULTATION		107.00*	71.30*	84.10*	028
029 PSYCHOTHERAPY-ONE HOUR		57.00*	65.00	57.00*	029
030 PSYCHOTHERAPY-HALF HOUR		35.00	40.00	34.20*	030
031 CHIROPRACTIC OFFICE VISIT	15.00	15.80*	13.70*	12.70*	031
032 INITIAL PHYSIOTHERAPY		11.70	11.70	11.70	032
033 F/U PODIATRIC OFFICE VISIT		18.00	15.00	15.00	033
034 ELECTROCARDIOGRAM (EKG)	23.00	30.00	28.50*	28.00	034
035 EKG-INTERPRET-REPORT ONLY	15.00	15.00	15.00	13.00	035
036 ARTERIAL BLOOD GAS STUDY		72.93*	72.93*	81.57*	036
037 ELECTROENCEPHALOGRAPH (EEG)		75.00	81.30*	71.30*	037
038 CHEMOTHERAPY					038
039 COLLECTION OF SPECIMENS		5.00	5.00	5.00	039
040 DEBRIDEMENT OF NAILS		20.00*	20.00*	20.00*	040
041 SKIN BIOPSY		45.00	36.40*	40.00	041
042 CHEMOCAUTERY		25.00	22.80*	22.80*	042
043 RADICAL MASTECTOMY		1426.00*	1026.70*	1026.70*	043
044 OPEN REDUCTION OF FRACTURE		1498.40*	1195.30*	1254.90*	044
045 ARTHROCENTESIS-MAJOR JOINT		20.00	28.50*	30.00*	045
046 ARTHROTOMY		20.00	20.00	20.00	046
047 ARTHROPLASTY-REPAIR OF HIP	20.00	20.00	2000.00	2000.00	047
048 NEEDLE PUNCTURE OF BURSA		25.00	25.00	24.70*	048
049 BRONCHOSCOPY		210.00	192.50	192.50*	049
050 THORACENTESIS		50.00	49.90*	45.00	050

1979 PREVAILING CHARGE SUMMARY DATA OCCIDENTAL LIFE INSURANCE CO.

CALIFORNIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	PSRO-25	PSRO-26	PSRO-27	PSRO-28
051 CATHETERIZATION OF HEART	570.40*	570.40*	570.40*	550.00
052 INSERTION OF PACEMAKER	891.25*	960.00	891.25*	974.00
053 PARTIAL COLECTOMY	1500.00	1197.80*	1026.70*	1026.70*
054 APPENDECTOMY	513.40*	513.40*	513.40*	501.20*
055 Sigmoidoscopy	47.60*	36.20*	38.50*	32.90*
056 HEMORRHOIDECTOMY	450.00	427.80*	427.80*	385.00*
057 CHOLECYSTECTOMY	1015.00	827.10*	855.60*	827.10*
058 REPAIR HERNIA	713.00*	513.40*	484.80*	523.30*
059 DIAGNOSTIC CYSTOURETHROSCOPY	85.00	66.60*	59.90*	61.00*
060 DILATION OF URETHRA	20.00	25.00	25.00	21.40*
061 PROSTATECTOMY	1500.00	1140.80*	1140.80*	1120.00
062 ELECTROSECTION-PROSTATE (TUR)	1311.90*	1112.30*	998.20*	1026.70*
063 HYSTERECTOMY	1069.50*	998.20*	962.60*	926.90*
064 INITIAL COMPLETE EYE EXAM	40.00	35.00	36.00	33.60
065 COMPREHENSIVE EYE EXAM	42.78*	34.22*	40.00*	35.00*
066 EYE EXAM WITH TONOMETRY	20.00	14.30*	15.70	15.00
067 EXTRACTION OF LENS	1212.10*	954.00*	926.90*	950.00
068 CHEST X-RAY, SINGLE VIEW	24.20*	20.50	18.00	21.40*
069 CHEST X-RAY, TWO VIEWS	28.50	30.00	27.80*	29.50
070 X-RAY SPINE	57.00*	59.20*	64.00	60.00
071 X-RAY HIP	35.70*	35.00	31.40*	34.90*
072 X-RAY UPPER GI TRACT	70.00	69.20*	64.20*	66.00
073 X-RAY COLON	70.00	64.20*	57.00	64.20*
074 RADIATION THERAPY-LOW VOLT	31.12*	29.16*	31.70*	31.70*
075 RADIATION THERAPY-SUPER VOLT	42.30*	42.30*	45.60*	39.90*
076 RADIATION THERAPY-MEGAVOLT	48.00	48.00	48.00	48.00
077 CAT SCAN - HEAD	225.00	225.00	225.00	225.00
078 CAT SCAN-HEAD, INTERPRET ONLY	90.00	90.00	90.00	90.00
079 THREE CHEMISTRY TESTS	26.00	25.00	21.50	20.00
080 TWELVE CHEMISTRY TESTS	30.00	25.00	25.00	20.60
081 CULTURE-OTHER THAN BLOOD	10.00	8.00	10.00	10.00
082 HEMOGLOBIN	8.00	5.00	4.00	4.60
083 AUTOMATED BLOOD COUNT	10.00	7.00	6.00	6.90
084 WHITE CELL COUNT	6.00	5.00	2.00	4.00
085 COMPLETE BLOOD COUNT (CBC)	10.00	10.00	10.00	10.00
086 CHOLESTEROL TEST	10.00	8.00	8.50	8.80
087 FLOCCULATION TEST	7.00	5.00	7.00	7.00
088 HEMATOCRIT	4.50	5.00	4.00	5.00
089 PLATELET COUNT (REES-ECKER)	10.00	8.00	6.50	8.40
090 POTASSIUM TEST	10.00	8.50	8.50	8.50
091 PROTHROMBIN	9.00	7.00	7.00	7.40
092 SEDIMENTATION RATE	7.00	6.00	7.00	6.00
093 BLOOD SUGAR	10.00	8.00	8.25	8.75
094 SUN-UREA, NITROGEN	10.00	8.00	9.00	8.50
095 URIC ACID	9.00	9.00	8.50	8.50
096 FECES-OCULT BLOOD	6.00	6.00	6.00	6.00
097 PAP TEST	12.00	15.00	10.00	9.50
098 ROUTINE URINALYSIS	7.00	6.00	6.00	6.00
099 CHEMICAL URINALYSIS	6.00	5.00	3.00	4.80
100 PATHOLOGY-THREE SPECIMENS	25.00	20.00	25.00	21.40

COLORADO

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LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

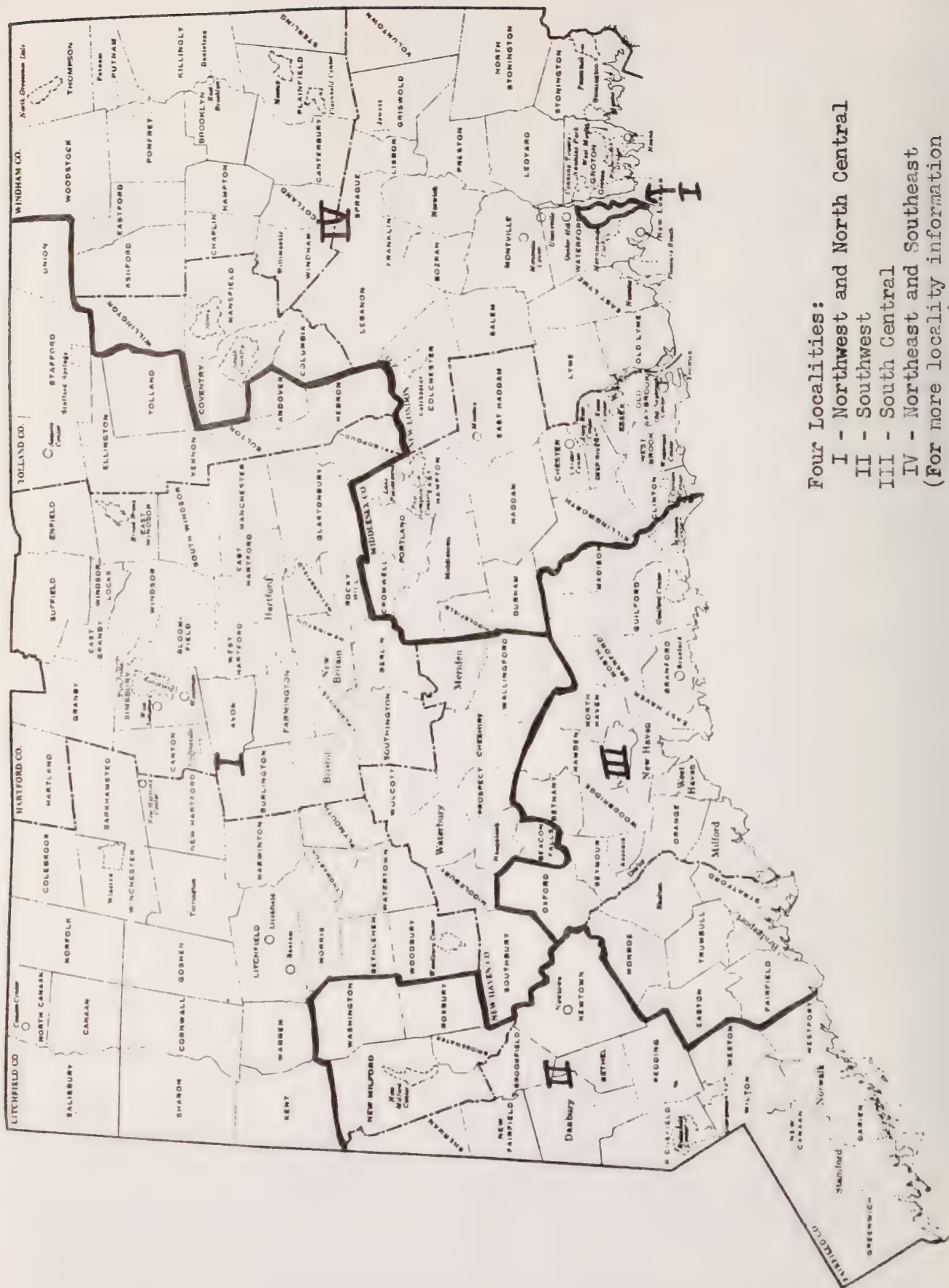
PROCEDURE DESCRIPTION	SINGLE	SINGLE
001 INITIAL BRIEF OFFICE VISIT		15.00
002 INITIAL LIMITED OFFICE VISIT	22.50	35.00
003 INIT INTERMED OFFICE VISIT		35.00
004 INIT COMP OFFICE VISIT	37.50	50.00
005 MINIMAL F/U OFFICE VISIT	5.00	6.00
006 BRIEF F/U OFFICE VISIT	8.60*	10.70
007 LIMITED F/U OFFICE VISIT	10.00	12.00
008 INTERMED F/U OFFICE VISIT	12.00	15.00
009 EXTENDED F/U OFFICE VISIT	15.00	20.00
010 COMPLETE F/U OFFICE VISIT	30.00	42.00
011 BRIEF F/U HOME VISIT	15.00	15.00
012 LIMITED F/U HOME VISIT		17.00
013 INTERMEDIATE F/U HOME VISIT	25.00	27.50
014 EXTENDED CARE FACILITY VISIT		17.10
015 BRIEF F/U NURSING HOME VISIT	10.00	12.00
016 INITIAL BRIEF HOSPITAL VISIT	30.00	35.60
017 INIT INTERMED HOSPITAL VISIT		37.50*
018 INITIAL COMP HOSPITAL VISIT	49.90	57.10
019 BRIEF F/U HOSPITAL VISIT	10.00	11.30*
020 LIMITED F/U HOSPITAL VISIT	13.90	14.70*
021 INTERMED F/U HOSPITAL VISIT		25.70
022 EXTENDED F/U HOSPITAL VISIT		15.00
023 BRIEF EMERGENCY ROOM VISIT		22.50
024 LIMITED EMERGENCY ROOM VISIT		22.50
025 INTERMED EMERGENCY ROOM VISIT	21.40*	35.00
026 LIMITED CONSULTATION		37.50*
027 EXTENSIVE CONSULTATION		59.90
028 COMPREHENSIVE CONSULTATION		42.80
029 PSYCHOTHERAPY-ONE HOUR		25.00
030 PSYCHOTHERAPY-HALF HOUR		10.00
031 CHIROPRACTIC OFFICE VISIT	7.50*	15.00
032 INITIAL PHYSIOTHERAPY		12.00
033 F/U PODIATRIC OFFICE VISIT		21.40
034 ELECTROCARDIOGRAM (EKG)	21.40	11.30*
035 EKG-INTERPRET, REPORT ONLY	10.00	15.00
036 ARTERIAL BLOOD GAS STUDY		49.90
037 ELECTROENCEPHALOGRAM (EEG)		18.40
038 CHEMOTHERAPY		5.50
039 COLLECTION OF SPECIMENS		15.00
040 DEBRIDEMENT OF NAILS		19.20
041 SKIN BIOPSY		2.50
042 CHEMOCAUTERY		684.70
043 RADICAL MASTECTOMY		726.00*
044 OPEN REDUCTION OF FRACTURE		17.20*
045 ARTHROCENTESIS-MAJOR JOINT		17.20*
046 ARTHROTOMY	18.70	855.80*
047 ARTHROPLASTY-REPAIR OF HIP		21.00
048 NEEDLE PUNCTURE OF BURSA		128.40
049 BRONCHOSCOPY		37.00
050 THORACENTESIS		

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	SINGLE	SINGLE
051 CATHETERIZATION OF HEART		450.00
052 INSERTION OF PACEMAKER		713.20
053 PARTIAL COLECTOMY		684.70
054 APPENDECTOMY		300.00*
055 S.GMOIOSCOPY	21.40	21.40*
056 HEMORRHOIDECTOMY		273.90
057 CHOLECYSTECTOMY		599.10
058 REPAIR HERNIA		299.50*
059 DIAGNOSTIC CYSTOURETHROSCOPY	55.00	51.40*
060 DILATION OF URETHRA		14.30*
061 PROSTATECTOMY		641.90*
062 ELECTROSECTION-PROSTATE (TUR)	570.60	641.90*
063 HYSTERECTOMY		690.00
064 INITIAL COMPLETE EYE EXAM		30.00
065 COMPREHENSIVE EYE EXAM		23.90
066 EYE EXAM WITH TONOMETRY		10.30
067 EXTRACTION OF LENS	620.00	599.10*
068 CHEST X-RAY, SINGLE VIEW	17.00	14.00
069 CHEST X-RAY, TWO VIEWS	21.40	21.00
070 X-RAY SPINE		45.00
071 X-RAY HIP		22.00
072 X-RAY UPPER GI TRACT	49.90	49.90
073 X-RAY COLON		42.00
074 RADIATION THERAPY-LOW VOLT	16.06	17.00
075 RADIATION THERAPY-SUPER VOLT	29.20	28.40
076 RADIATION THERAPY-MEGAVOLT		28.40
077 CAT SCAN - HEAD		59.20*
078 CAT SCAN-HEAD, INTERPRET ONLY		49.00
079 THREE CHEMISTRY TESTS		16.00
080 TWELVE CHEMISTRY TESTS		10.00
081 CULTURE-OTHER THAN BLOOD		3.00
082 HEMOGLOBIN		7.00
083 AUTOMATED BLOOD COUNT		3.00
084 WHITE CELL COUNT		7.00
085 COMPLETE BLOOD COUNT (CBC)		3.00
086 CHOLESTEROL TEST		7.00
087 FLOCCULATION TEST		8.00
088 HEMATOCRIT		3.00
089 PLATELET COUNT (REES-ECKER)		6.00
090 POTASSIUM TEST		9.00
091 PROTHROMBIN		5.00
092 SEDIMENTATION RATE		5.00
093 BLOOD SUGAR		8.00
094 EUN-UREA, NITROGEN		8.00
095 URIC ACID		8.00
096 FECES-OCULT BLOOD		5.00
097 PAP TEST		7.00
098 ROUTINE URINALYSIS		4.00
099 CHEMICAL URINALYSIS		4.00
100 PATHOLOGY-THREE SPECIMENS		18.00

CONNECTICUT

CONNECTICUT



- Four Localities:
- I - Northwest and North Central
 - II - Southwest
 - III - South Central
 - IV - Northeast and Southeast
- (For more locality information see Appendix A)

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

I

II

III

IV

I

II

III

IV

001 INITIAL BRIEF OFFICE VISIT	35.60*	40.00	28.50*	28.50*	21.30*	25.00	21.30*	21.30*	001
002 INITIAL LIMITED OFFICE VISIT					42.80*	42.80*	40.00	35.00	002
003 INIT INTERMED OFFICE VISIT					42.80*	42.80*	40.00	35.00	003
004 INIT COMP OFFICE VISIT	30.00	30.00	20.00	30.00	49.90*	50.00	50.00	31.50*	004
005 MINIMAL F/U OFFICE VISIT	6.00	6.00	7.10*	5.00	7.10*	7.10*	7.10*	7.10*	005
006 BRIEF F/U OFFICE VISIT	12.80*	11.30*	14.30*	11.30*	14.30*	17.10*	14.30*	14.30*	006
007 LIMITED F/U OFFICE VISIT	20.00	10.00	15.00	12.00	15.00	21.30*	20.00	15.00	007
008 INTERMED F/U OFFICE VISIT	20.00	17.70*	10.00	12.90*	25.00	25.00	20.00	12.00	008
009 EXTENDED F/U OFFICE VISIT	20.00	15.00	15.00	20.00	25.00	35.00	25.00	20.00	009
010 COMPLETE F/U OFFICE VISIT	40.00	40.00	41.70*	25.00	40.00	42.80*	45.00	25.00	010
011 BRIEF F/U HOME VISIT	17.10*	21.30*	17.10*	17.10*	20.00	28.50*	21.30*	17.10*	011
012 LIMITED F/U HOME VISIT					20.00	28.50*	20.00	15.00	012
013 INTERMEDIATE F/U HOME VISIT	27.50	25.00	20.00	21.50*	20.00	28.50*	20.00	15.00	013
014 EXTENDED CARE FACILITY VISIT					16.00	21.30*	20.00	14.30*	014
015 BRIEF F/U NURSING HOME VISIT	14.30*	17.10*	14.30*	14.30*	16.00	21.30*	20.00	14.30*	015
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	35.00	28.50*	28.50*	35.00	35.00	35.00	35.00	016
017 INIT INTERMED HOSPITAL VISIT					50.00	49.90*	49.90*	35.60*	017
018 INITIAL COMP HOSPITAL VISIT	35.60*	35.60*	35.60*	35.60*	50.00	65.00	50.00	50.00	018
019 BRIEF F/U HOSPITAL VISIT	14.30*	14.30*	14.30*	14.30*	14.30*	21.30*	14.30*	14.30*	019
020 LIMITED F/U HOSPITAL VISIT	20.00	15.00	15.00	17.10*	17.00	25.00	15.00	20.00	020
021 INTERMED F/U HOSPITAL VISIT	20.00	15.00	15.00	17.10*	17.00	25.00	15.00	20.00	021
022 EXTENDED F/U HOSPITAL VISIT					20.00	24.50*	15.00	20.00	022
023 BRIEF EMERGENCY ROOM VISIT					25.00	25.00	25.00	25.00	023
024 LIMITED EMERGENCY ROOM VISIT					25.00	25.00	25.00	25.00	024
025 INTERMED EMERGENCY ROOM VISIT	35.00	30.00	35.60*	40.00	49.90*	50.00	49.90*	49.90	025
026 LIMITED CONSULTATION					50.00	75.00	60.00	60.00	026
027 EXTENSIVE CONSULTATION					75.00	80.00	65.00	57.00	027
028 COMPREHENSIVE CONSULTATION					40.70*	49.90*	49.90*	35.60*	028
029 PSYCHOTHERAPY-ONE HOUR					20.40*	25.00	25.00	21.00	029
030 PSYCHOTHERAPY-HALF HOUR					11.50*	13.90*	13.10*	11.70*	030
031 CHIROPRACTIC OFFICE VISIT	11.50*	13.90*	13.10*	11.70*	11.50*	13.90*	13.10*	11.70*	031
032 INITIAL PHYSIOTHERAPY					21.30*	25.00	21.30*	21.30*	032
033 F/U PODIATRIC OFFICE VISIT					12.80*	11.30*	14.30*	11.30*	033
034 ELECTROCARDIOGRAM (EKG)	20.00	21.30*	20.00	20.00	20.00	25.00	20.00	20.00	034
035 EKG-INTERPRET-REPORT ONLY	10.00	10.00	10.00	10.00	10.00	10.00	5.00	10.00	035
036 ARTERIAL BLOOD GAS STUDY					10.70*	15.00	15.00	25.00	036
037 ELECTROENCEPHALOGRAM (EEG)					61.60*	60.00	55.00	60.00	037
038 CHEMOTHERAPY									038
039 COLLECTION OF SPECIMENS					5.00	10.00	5.00	5.00	039
040 DEBRIDEMENT OF NAILS					20.00	20.00	20.00	20.00	040
041 SKIN BIOPSY					30.00	35.00	30.00	25.00	041
042 CHEMOCAUTERY					25.00	21.30*	25.00	25.00	042
043 RADICAL MASTECTOMY					630.00	700.00	700.00	700.00	043
044 OPEN REDUCTION OF FRACTURE					741.40*	900.00	850.00	713.00*	044
045 ARTHROCTESIS-MAJOR JOINT					20.00	20.00	20.00	19.00	045
046 ARTHROTOMY					20.00	20.00	20.00	19.00	046
047 ARTHROPLASTY-REPAIR OF HIP					750.00	850.00	850.00	798.60*	047
048 NEEDLE PUNCTURE OF BURSA					20.00	20.00	20.00	19.00	048
049 BRONCHOSCOPY					165.00	213.90*	200.00	160.00	049
050 THORACENTESIS	17.00	10.00	21.30*	20.00	40.00	50.00	40.00	28.50*	050

1979 PREVAILING CHARGE SUMMARY DATA CONNECTICUT GENERAL LIFE INS.

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE				LOCALITY DESIGNATION FOR SPECIALIST			
	I	II	III	IV	I	II	III	IV
051 CATHETERIZATION OF HEART	425.00				450.00		450.00	450.00
052 INSERTION OF PACEMAKER	775.00				713.00*		798.60*	340.00
053 PARTIAL COLECTOMY	783.00				1000.00		900.00	698.50*
054 APPENDECTOMY	420.00				420.00		420.00	359.50*
055 SIGMOIDOSCOPY	25.00				30.00		28.50*	25.00
056 HEMORRHOIDECTOMY	280.00			25.00	280.00		328.00*	275.00
057 CHOLECYSTECTOMY	550.00				713.00*		641.70*	522.50*
058 REPAIR HERNIA	350.00				499.10*		414.00*	302.50*
059 DIAGNOSTIC CYSTOURETHROSCOPY	66.00			66.00	71.30*		65.00	57.00
060 DILATION OF URETHRA	20.00				21.30*		21.30*	16.00
061 PROSTATECTOMY	684.50*				926.90*		850.00	641.70*
062 ELECTROSECTION-PROSTATE (TUR)	740.00	740.00	740.00	740.00	850.00		713.00*	713.00*
063 HYSTERECTOMY	698.70*				900.00		713.00*	641.70*
064 INITIAL COMPLETE EYE EXAM	25.00				28.00		28.00	20.00
065 COMPREHENSIVE EYE EXAM	25.00				28.00		28.00	20.00
066 EYE EXAM WITH TONOMETRY	18.00				20.00		15.00	15.00
067 EXTRACTION OF LENS	713.00*			800.00	998.20*		713.00*	650.00
068 CHEST X-RAY, SINGLE VIEW	15.00	15.00	15.00	14.30*	22.00		14.30*	14.30*
069 CHEST X-RAY, TWO VIEWS	25.00	25.00	25.00	21.30*	28.50*		25.00	21.30*
070 X-RAY SPINE	40.00				44.20*		39.00	34.00
071 X-RAY HIP	25.00				28.50*		27.00	23.00
072 X-RAY UPPER GI TRACT	62.40*	73.20*	75.00	75.00	75.60*		64.10*	50.00
073 X-RAY COLON	64.10*				71.30*		64.10*	50.00
074 RADIATION THERAPY-LOW VOLT	23.60	23.60	23.60	23.60	21.30*		21.30*	17.10*
075 RADIATION THERAPY-SUPER VOLT	18.80	18.80	18.80	18.80	14.20*		22.40*	17.10*
076 RADIATION THERAPY-MEGAVOLT								
077 CAT SCAN - HEAD	115.00				115.00		115.00	115.00
078 CAT SCAN-HEAD, INTERPRET ONLY	35.00				35.00		35.00	35.00
079 THREE CHEMISTRY TESTS								
080 TWELVE CHEMISTRY TESTS	12.00	12.00	12.00		12.00		12.00	15.00
081 CULTURE-OTHER THAN BLOOD	7.00	13.00			13.00		8.00	10.00
082 HEMOGLOBIN	3.00	4.00			4.00		3.00	3.00
083 AUTOMATED BLOOD COUNT								
084 WHITE CELL COUNT	3.00	5.00			5.00		5.00	3.00
085 COMPLETE BLOOD COUNT (CBC)	3.00	10.00			10.00		9.00	9.00
086 CHOLESTEROL TEST	6.60	7.00			7.00		6.60	7.00
087 FLOCCULATION TEST	5.00	4.00			4.00		5.00	4.25
088 HEMATOCRIT	3.00	5.00			5.00		3.00	2.50
089 PLATELET COUNT (REES-ECKER)	5.50	7.00			7.00		5.00	7.00
090 POTASSIUM TEST	7.00	8.00			8.00		6.60	7.00
091 PROTHROMBIN	6.00	6.00			6.00		5.50	5.50
092 SEDIMENTATION RATE	3.50	5.00			5.00		4.00	4.00
093 BLOOD SUGAR	6.00	7.00			7.00		6.00	6.00
094 BUN-UREA, NITROGEN	6.50	8.00			8.00		6.00	7.00
095 URIC ACID	6.00	8.00			8.00		6.00	7.00
096 FECES-OCCULT BLOOD	3.00	5.00			5.00		3.00	3.00
097 PAP TEST	6.00	10.00			10.00		6.00	6.00
098 ROUTINE URINALYSIS	4.00	5.00			5.00		5.00	4.00
099 CHEMICAL URINALYSIS	4.00	5.00			5.00		5.00	4.00
100 PATHOLOGY-THREE SPECIMENS	20.00	20.00			20.00		20.00	20.00

DELAWARE

DELAWARE



One Locality - Statewide

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	SINGLE	SINGLE
001 INITIAL BRIEF OFFICE VISIT	10.00*	14.30*
002 INITIAL LIMITED OFFICE VISIT		14.30*
003 INIT INTERMED OFFICE VISIT		20.00
004 INIT COMP OFFICE VISIT	30.00	49.90*
005 MINIMAL F/U OFFICE VISIT	10.00*	14.30*
006 BRIEF F/U OFFICE VISIT	10.00*	14.30*
007 LIMITED F/U OFFICE VISIT	12.00	20.00
008 INTERMED F/U OFFICE VISIT	12.00	20.00
009 EXTENDED F/U OFFICE VISIT	15.00	30.00
010 COMPLETE F/U OFFICE VISIT	30.00	49.90*
011 BRIEF F/U HOME VISIT	14.30*	
012 LIMITED F/U HOME VISIT		
013 INTERMEDIATE F/U HOME VISIT	16.00	
014 EXTENDED CARE FACILITY VISIT		20.00
015 BRIEF F/U NURSING HOME VISIT	12.09*	16.12*
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	35.70*
017 INIT INTERMED HOSPITAL VISIT		49.90*
018 INITIAL COMP HOSPITAL VISIT	35.00	60.00
019 BRIEF F/U HOSPITAL VISIT	10.00*	14.30*
020 LIMITED F/U HOSPITAL VISIT	14.30*	35.00
021 INTERMED F/U HOSPITAL VISIT	14.30*	17.10*
022 EXTENDED F/U HOSPITAL VISIT		22.80*
023 BRIEF EMERGENCY ROOM VISIT		13.60
024 LIMITED EMERGENCY ROOM VISIT		13.60
025 INTERMED EMERGENCY ROOM VISIT		23.80
026 LIMITED CONSULTATION	21.40	35.70*
027 EXTENSIVE CONSULTATION		49.90*
028 COMPREHENSIVE CONSULTATION		65.00
029 PSYCHOTHERAPY-ONE HOUR		42.80*
030 PSYCHOTHERAPY-HALF HOUR		21.40*
031 CHIROPRACTIC OFFICE VISIT	9.60	12.00
032 INITIAL PHYSIOTHERAPY		11.10
033 F/U PODIATRIC OFFICE VISIT		10.00
034 ELECTROCARDIOGRAM (EKG)	25.00	25.00
035 EKG-INTERPRET. REPORT ONLY	10.00	10.00
036 ARTERIAL BLOOD GAS STUDY		20.00
037 ELECTROENCEPHALOGRAM (EEG)		75.00
038 CHEMOTHERAPY		
039 COLLECTION OF SPECIMENS		5.00
040 DEDRIMENT OF NAILS		42.80*
041 SKIN BIOPSY		21.40*
042 CHEMOCAUTERY		21.40
043 RADICAL MASTECTOMY		855.60
044 OPEN REDUCTION OF FRACTURE		957.20
045 ARTHROCENTESIS-MAJOR JOINT		35.70*
046 ARTHROCTOMY		35.70*
047 ARTHROPLASTY-REPAIR OF HIP	21.40*	941.20*
048 NEEDLE PUNCTURE OF BURSA		20.00*
049 BRONCHOSCOPY		292.00*
050 THORACENTESIS		71.30*

1979 PREVAILING CHARGE SUMMARY DATA B/C-B/S OF DELAWARE

DELAWARE

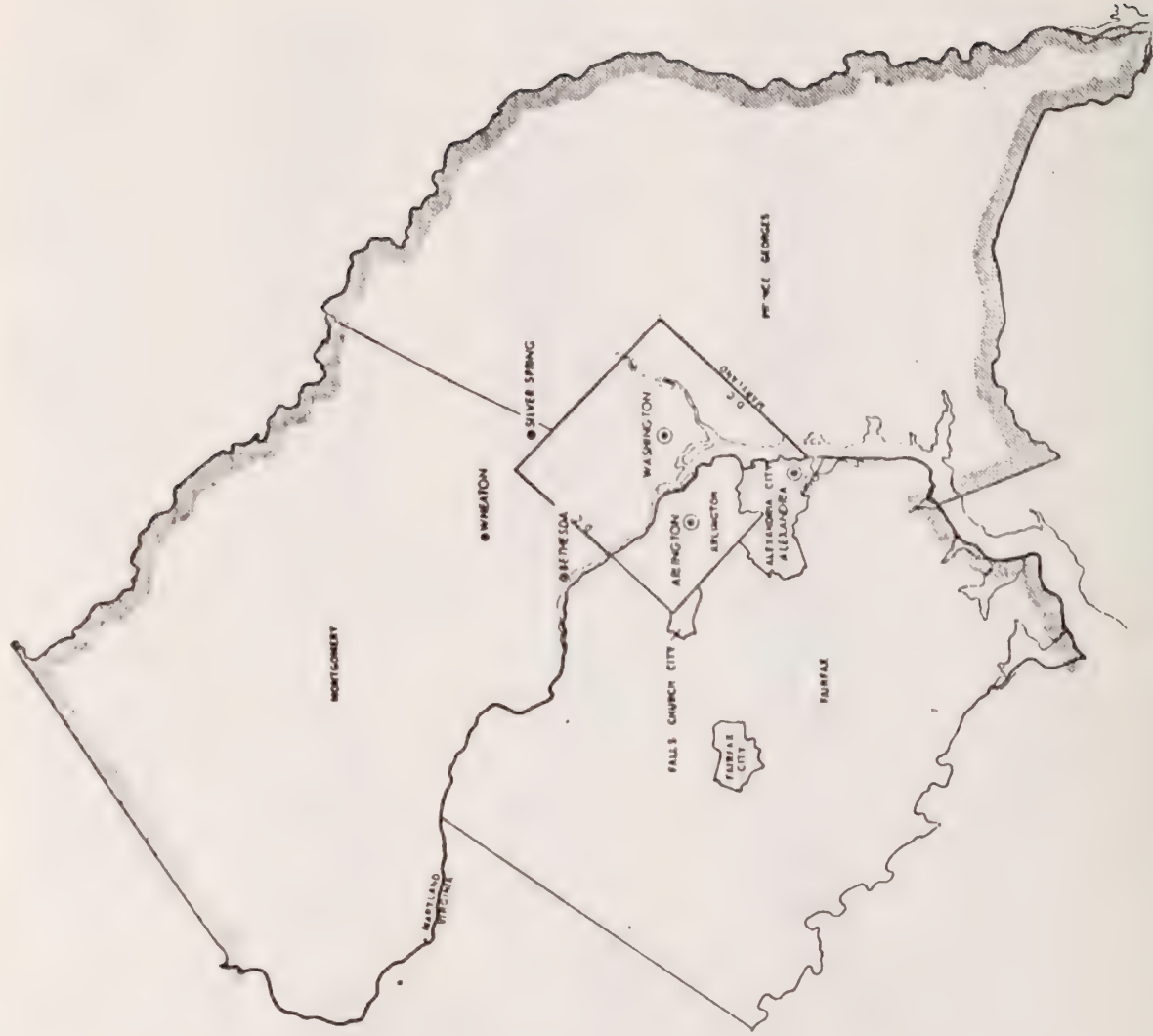
LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION SINGLE SINGLE

051	CATHERIZATION OF HEART				348.40	051
052	INSERTION OF PACEMAKER				957.20	052
053	PARTIAL COLECTOMY				1069.50*	053
054	APPENDECTOMY				320.90*	054
055	SIGMOIDOSCOPY	25.00			35.70*	055
056	HEMORRHOIDECTOMY				356.50*	056
057	CHOLECYSTECTOMY				499.10*	057
058	REPAIR HERNIA				320.90*	058
059	DIAGNOSTIC CYSTOURETHROSCOPY	76.60			71.30*	059
060	DILATION OF URETHRA				20.00	060
061	PROSTATECTOMY				713.00	061
062	ELECTROSECTION-PROSTATE (TUR)	713.00			713.00*	062
063	HYSTERECTOMY				635.20*	063
064	INITIAL COMPLETE EYE EXAM				28.50*	064
065	COMPREHENSIVE EYE EXAM				25.00	065
066	EYE EXAM WITH TONOMETRY				14.30	066
067	EXTRACTION OF LENS	641.70			641.90*	067
068	CHEST X-RAY, SINGLE VIEW	15.70			23.00	068
069	CHEST X-RAY, TWO VIEWS	22.80			27.10	069
070	X-RAY SPINE				28.00	070
071	X-RAY HIP				27.10	071
072	X-RAY UPPER GI TRACT	57.00			68.00	072
073	X-RAY COLON				58.00	073
074	RADIATION THERAPY-LOW VOLT	16.00*			16.00*	074
075	RADIATION THERAPY-SUPER VOLT	16.00			16.00	075
076	RADIATION THERAPY-MEGAVOLT				16.00	076
077	CAT SCAN - HEAD				16.00	077
078	CAT SCAN-HEAD, INTERPRET ONLY				219.50	078
079	THREE CHEMISTRY TESTS				100.00	079
080	TWELVE CHEMISTRY TESTS				14.00	080
081	CULTURE-OTHER THAN BLOOD				15.00	081
082	HEMOGLOBIN				3.00	082
083	AUTOMATED BLOOD COUNT				3.00	083
084	WHITE CELL COUNT				9.00	084
085	COMPLETE BLOOD COUNT (CBC)				6.50	085
086	CHOLESTEROL TEST				4.50	086
087	FLOCCULATION TEST				3.00	087
088	HEMATOCRIT				6.00	088
089	PLATELET COUNT (REES-ECKER)				5.00	089
090	POTASSIUM TEST				5.50	090
091	PROTHROMBIN				4.00	091
092	SEDIMENTATION RATE				5.00	092
093	BLOOD SUGAR				5.00	093
094	BUN-UREA, NITROGEN				5.00	094
095	URIC ACID				6.00	095
096	FECES-OCCULT BLOOD				3.30	096
097	PAP TEST				7.00	097
098	ROUTINE URINALYSIS				3.50	098
099	CHEMICAL URINALYSIS				3.50	099
100	PATHOLOGY-THREE SPECIMENS				15.00	100

DISTRICT OF COLUMBIA

DISTRICT OF COLUMBIA



One Locality:

Washington Metropolitan Area, includes Washington, D.C.; Prince Georges and Montgomery Counties in Maryland; Fairfax and Arlington Counties in Virginia and the city of Alexandria, Virginia

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE	LOCALITY DESIGNATION FOR SPECIALIST
001 INITIAL BRIEF OFFICE VISIT	SINGLE	SINGLE
002 INITIAL LIMITED OFFICE VISIT	44.20*	20.00
003 INIT INTERMED OFFICE VISIT		49.90*
004 INIT COMP OFFICE VISIT		20.00
005 MINIMAL F/U OFFICE VISIT	50.00	57.00*
006 BRIEF F/U OFFICE VISIT	14.30*	14.30
007 LIMITED F/U OFFICE VISIT	14.30*	14.30*
008 INTERMED F/U OFFICE VISIT	15.00	14.30
009 EXTENDED F/U OFFICE VISIT	20.00	20.00
010 COMPLETE F/U OFFICE VISIT	25.00	25.00
011 BRIEF F/U HOME VISIT	15.00	42.80*
012 LIMITED F/U HOME VISIT		15.00
013 INTERMEDIATE F/U HOME VISIT	22.80*	15.00
014 EXTENDED CARE FACILITY VISIT		25.00
015 BRIEF F/U NURSING HOME VISIT	14.30*	18.00
016 INITIAL BRIEF HOSPITAL VISIT	14.30*	14.30*
017 INIT INTERMED HOSPITAL VISIT		17.10
018 INITIAL COMP HOSPITAL VISIT	60.00	49.90*
019 BRIEF F/U HOSPITAL VISIT	14.30*	71.30*
020 LIMITED F/U HOSPITAL VISIT	14.30*	17.10*
021 INTERMED F/U HOSPITAL VISIT	20.00	17.10
022 EXTENDED F/U HOSPITAL VISIT		21.30*
023 BRIEF EMERGENCY ROOM VISIT		42.80*
024 LIMITED EMERGENCY ROOM VISIT		16.00
025 INTERMED EMERGENCY ROOM VISIT		16.00
026 LIMITED CONSULTATION	49.90*	25.00
027 EXTENSIVE CONSULTATION		65.00
028 COMPREHENSIVE CONSULTATION		71.30
029 PSYCHOTHERAPY-ONE HOUR		71.30*
030 PSYCHOTHERAPY-HALF HOUR		45.00
031 CHIROPRACTIC OFFICE VISIT	15.05	35.60*
032 INITIAL PHYSIOTHERAPY		11.00*
033 F/U PODIATRIC OFFICE VISIT		18.00
034 ELECTROCARDIOGRAM (EKG)	25.00	15.00
035 EKG-INTERPRET, REPORT ONLY	15.00	25.00
036 ARTERIAL BLOOD GAS STUDY		14.75
037 ELECTROENCEPHALOGRAM (EEG)		33.50
038 CHEMOTHERAPY		57.00*
039 COLLECTION OF SPECIMENS		18.00
040 DEBRIDEMENT OF NAILS		5.00
041 SKIN BIOPSY		15.00
042 CHEMOCAUTERY		39.90*
043 RADICAL MASTECTOMY		40.00
044 OPEN REDUCTION OF FRACTURE		713.00*
045 ARTHROCENTESIS-MAJOR JOINT		579.10*
046 ARTHROTOMY		25.00*
047 ARTHROPLASTY-REPAIR OF HIP	25.00	27.50
048 NEEDLE PUNCTURE OF BURSA		1040.00
049 BRONCHOSCOPY		20.00
050 THORACENTESIS		178.20*
		71.30*

1979 PREVAILING CHARGE SUMMARY DATA MEDICAL SERVICE OF D.C. WASHINGTON D.C.

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	SINGLE	SINGLE
051 CATHETERIZATION OF HEART		1069.50*
052 INSERTION OF PACEMAKER		1069.50*
053 PARTIAL COLECTOMY		356.50*
054 APPENDECTOMY		35.60*
055 SIGMOIDOSCOPY	25.00	350.00
056 HEMORRHOIDECTOMY		584.70*
057 CHOLECYSTECTOMY		420.00
058 REPAIR HERNIA		100.00
059 DIAGNOSTIC CYSTOURETHROSCOPY	100.00	21.30*
060 DILATION OF URETHRA		634.90*
061 PROSTATECTOMY		926.90*
062 ELECTROSECTION-PROSTATE (TUR)	855.00	713.00*
063 HYSTERECTOMY		28.50*
064 INITIAL COMPLETE EYE EXAM		28.50*
065 COMPREHENSIVE EYE EXAM		21.00
066 EYE EXAM WITH TONOMETRY	748.60*	748.60*
067 EXTRACTION OF LENS	18.00	17.10*
068 CHEST X-RAY, SINGLE VIEW	23.50*	23.50*
069 CHEST X-RAY, TWO VIEWS		42.00
070 X-RAY SPINE		25.00*
071 X-RAY HIP		61.00*
072 X-RAY UPPER GI TRACT	50.00	60.00
073 X-RAY COLON		48.00
074 RADIATION THERAPY-LOW VOLT	48.00	72.00
075 RADIATION THERAPY-SUPER VOLT	72.00	144.00
076 RADIATION THERAPY-MEGAVOLT		230.40*
077 CAT SCAN - HEAD		
078 CAT SCAN-HEAD, INTERPRET ONLY		25.00
079 THREE CHEMISTRY TESTS		13.50
080 TWELVE CHEMISTRY TESTS		5.60
081 CULTURE-OTHER THAN BLOOD		8.00
082 HEMOGLOBIN		6.00
083 AUTOMATED BLOOD COUNT		8.00*
084 WHITE CELL COUNT		7.00
085 COMPLETE BLOOD COUNT (CBC)		7.00
086 CHOLESTEROL TEST		5.00
087 FLOCCULATION TEST		5.00
088 HEMATOCRIT		6.00
089 PLATELET COUNT (REES-ECKER)		6.00
090 POTASSIUM TEST		6.00
091 PROTHROMBIN		5.00
092 SEDIMENTATION RATE		6.00
093 BLOOD SUGAR		6.00
094 BUN-UREA, NITROGEN		6.60
095 URIC ACID		3.00
096 FECES-OCCULT BLOOD		10.00
097 PAP TEST		5.00
098 ROUTINE URINALYSIS		3.90
099 CHEMICAL URINALYSIS		20.00
100 PATHOLOGY-THREE SPECIMENS		

FLORIDA

1979 PREVAILING CHARGE SUMMARY DATA B/S OF FLORIDA

FLORIDA

COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION	AREA A	AREA B	AREA C
001 INITIAL BRIEF OFFICE VISIT	17.00	20.00	20.00
002 INITIAL LIMITED OFFICE VISIT	20.00	22.00	25.00
003 INIT INTERMED OFFICE VISIT	20.00	25.00	30.00
004 INIT COMP OFFICE VISIT	30.00	43.75*	40.00
005 MINIMAL F/U OFFICE VISIT	6.70*	7.00	7.00
006 BRIEF F/U OFFICE VISIT	11.00	14.30*	14.30*
007 LIMITED F/U OFFICE VISIT	12.00	14.30*	15.60*
008 INTERMED F/U OFFICE VISIT	15.00	15.00	20.00
009 EXTENDED F/U OFFICE VISIT	15.00	20.00	20.00
010 COMPLETE F/U OFFICE VISIT	25.00	42.00	40.00
011 BRIEF F/U HOME VISIT	21.40*	20.00	25.00
012 LIMITED F/U HOME VISIT	20.00	21.40*	25.00
013 INTERMEDIATE F/U HOME VISIT	18.40*	23.50*	30.00
014 EXTENDED CARE FACILITY VISIT	15.00	15.00	23.80*
015 BRIEF F/U NURSING HOME VISIT	12.40*	14.50*	17.10*
016 INITIAL BRIEF HOSPITAL VISIT	35.00	49.90*	50.00
017 INIT INTERMED HOSPITAL VISIT	40.00	50.00	50.00
018 INITIAL COMP HOSPITAL VISIT	40.00	49.90*	60.00
019 BRIEF F/U HOSPITAL VISIT	15.00	16.00	25.00
020 LIMITED F/U HOSPITAL VISIT	15.00	17.10*	25.00
021 INTERMED F/U HOSPITAL VISIT	15.00	20.00	25.00
022 EXTENDED F/U HOSPITAL VISIT	15.00	25.00	25.00
023 BRIEF EMERGENCY ROOM VISIT	17.00	20.00	25.00
024 LIMITED EMERGENCY ROOM VISIT	20.00	22.00	25.00
025 INTERMED EMERGENCY ROOM VISIT	20.00	25.00	30.00
026 LIMITED CONSULTATION	27.80*	32.80*	38.60*
027 EXTENSIVE CONSULTATION	43.50*	50.00	50.00
028 COMPREHENSIVE CONSULTATION	50.00	60.00	75.00
029 PSYCHOTHERAPY-ONE HOUR	49.90*	49.90*	57.00*
030 PSYCHOTHERAPY-HALF HOUR	25.00	30.00	37.80*
031 CHIROPRACTIC OFFICE VISIT	11.00	12.00	13.30*
032 INITIAL PHYSIOTHERAPY	11.40*	11.40*	14.30*
033 F/U PODIATRIC OFFICE VISIT	12.00	14.30*	15.60
034 ELECTROCARDIOGRAM (EKG)	21.40*	21.40*	25.00
035 EKG-INTERPRET. REPORT ONLY	10.00	14.00	10.00
036 ARTERIAL BLOOD GAS STUDY	38.50	35.00	40.00
037 ELECTROENCEPHALOGRAM (EEG)	65.00	60.00	50.00
038 CHEMOTHERAPY	23.10	26.70	32.00
039 COLLECTION OF SPECIMENS	3.00	3.00	3.00
040 DEBRIDEMENT OF NAILS	14.00*	14.60*	15.50*
041 SKIN BIOPSY	28.00	29.10*	30.00
042 CHEMOCAUTERY	5.00	5.30*	5.90*
043 RADICAL MASTECTOMY	842.60*	850.00	934.00*
044 OPEN REDUCTION OF FRACTURE	983.10*	1000.00	1089.60*
045 ARTHROCENTESIS-MAJOR JOINT	20.00*	20.00	20.00
046 ARTHROTOMY	14.30*	16.00	20.00
047 ARTHROPLASTY-REPAIR OF HIP	1400.00	1400.00	1400.00
048 NEEDLE PUNCTURE OF BURSA	17.50*	18.10*	19.40*
049 BRONCHOSCOPY	175.00	178.25*	178.25*
050 THORACENTESIS	31.70*	32.70*	35.10*

COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION

AREA A	AREA B	AREA C
484.80*	502.00*	537.50*
1000.00	1000.00	1000.00
713.00*	784.30*	934.00*
400.00	420.00	451.60*
28.10*	29.00*	35.00
352.00	400.00	427.80*
570.40*	613.20*	713.00*
320.90*	356.60*	427.80*
40.00	49.90*	50.60*
17.50*	17.00	21.40*
713.00*	784.30*	895.10*
713.00*	713.00*	962.60*
737.20*	750.00	817.20*
30.00	30.00	30.00
25.00	30.00	35.00
11.80*	13.80*	15.00
641.70*	713.00*	784.30*
18.00	18.00	20.00
24.00	25.00	26.00
40.00	45.00	48.00
28.00	28.50*	28.50*
56.00	60.00	70.00
54.00	51.30*	60.00
18.30	18.30	18.80
28.00	28.00	28.00
40.00	40.00	40.00
150.00	150.00	150.00
36.00	36.00	36.00
10.50	10.50	10.00
12.60	15.60	12.60
20.00	16.00	20.00
5.00	5.00	5.00
6.30	6.30	6.30
4.00	5.00	4.00
10.00	9.00	10.00
6.30	6.30	8.40
6.30	4.20	5.30
8.00	5.00	5.00
6.00	6.30	8.40
5.30	5.30	5.30
5.30	5.30	6.30
6.30	6.30	6.30
6.30	6.30	8.40
6.00	5.00	5.00
10.00	9.00	10.00
4.20	4.20	5.30
2.00	5.00	5.00
30.00	30.00	30.00

051	CATHERIZATION OF HEART
052	INSERTION OF PACEMAKER
053	PARTIAL COLECTOMY
054	APPENDECTOMY
055	SIGMOIDOSCOPY
056	HEMORRHOIDECTOMY
057	CHOLECYSTECTOMY
058	REPAIR HERNIA
059	DIAGNOSTIC CYSTOURETHROSCOPY
060	DILATION OF URETHRA
061	PROSTATECTOMY
062	ELECTROSECTION-PROSTATE (TURP)
063	HYSTERECTOMY
064	INITIAL COMPLETE EYE EXAM
065	COMPREHENSIVE EYE EXAM
066	EYE EXAM WITH TONOMETRY
067	EXTRACTION OF LENS
068	CHEST X-RAY, SINGLE VIEW
069	CHEST X-RAY, TWO VIEWS
070	X-RAY SPINE
071	X-RAY HIP
072	X-RAY UPPER GI TRACT
073	X-RAY COLON
074	RADIATION THERAPY-LOW VOLT
075	RADIATION THERAPY-SUPER VOLT
076	RADIATION THERAPY-MEGAVOLT
077	CAT SCAN - HEAD
078	CAT SCAN-HEAD, INTERPRET ONLY
079	THREE CHEMISTRY TESTS
080	TWELVE CHEMISTRY TESTS
081	CULTURE-OTHER THAN BLOOD
082	HEMOGLOBIN
083	AUTOMATED BLOOD COUNT
084	WHITE CELL COUNT
085	COMPLETE BLOOD COUNT (CBC)
086	CHOLESTEROL TEST
087	FLOCCULATION TEST
088	HEMATOCRIT
089	PLATELET COUNT (REES-ECKER)
090	POTASSIUM TEST
091	PROTHROMBIN
092	SEDIMENTATION RATE
093	BLOOD SUGAR
094	BUN-UREA, NITROGEN
095	URIC ACID
096	FECES-OCCULT BLOOD
097	PAP TEST
098	ROUTINE URINALYSIS
099	CHEMICAL URINALYSIS
100	PATHOLOGY-THREE SPECIMENS

COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION

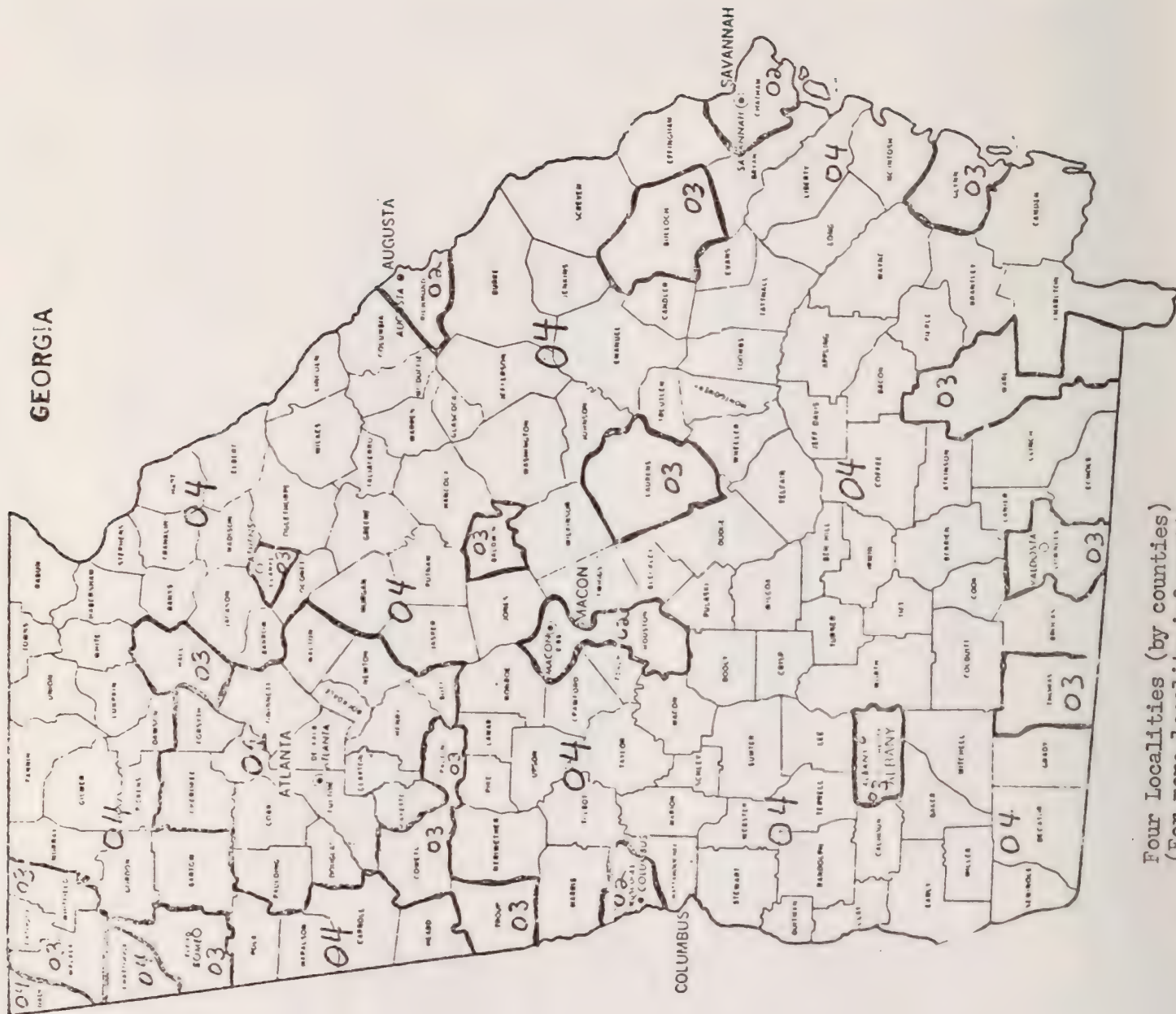
SINGLE

001	INITIAL BRIEF OFFICE VISIT	35.00	001
002	INITIAL LIMITED OFFICE VISIT	40.00	002
003	INIT INTERMED OFFICE VISIT	40.00	003
004	INIT COMP OFFICE VISIT	42.80*	004
005	MINIMAL F/U OFFICE VISIT	9.40*	005
006	BRIEF F/U OFFICE VISIT	17.10*	006
007	LIMITED F/U OFFICE VISIT	18.00*	007
008	INTERMED F/U OFFICE VISIT	25.00	008
009	EXTENDED F/U OFFICE VISIT	25.00	009
010	COMPLETE F/U OFFICE VISIT	30.00	010
011	BRIEF F/U HOME VISIT	28.50*	011
012	LIMITED F/U HOME VISIT	28.50*	012
013	INTERMEDIATE F/U HOME VISIT	35.00	013
014	EXTENDED CARE FACILITY VISIT	23.60*	014
015	BRIEF F/U NURSING HOME VISIT	17.10*	015
016	INITIAL BRIEF HOSPITAL VISIT	50.00	016
017	INIT INTERMED HOSPITAL VISIT	60.00	017
018	INITIAL COMP HOSPITAL VISIT	71.40*	018
019	BRIEF F/U HOSPITAL VISIT	25.00	019
020	LIMITED F/U HOSPITAL VISIT	25.00	020
021	INTERMED F/U HOSPITAL VISIT	30.00	021
022	EXTENDED F/U HOSPITAL VISIT	30.00	022
023	BRIEF EMERGENCY ROOM VISIT	25.00	023
024	LIMITED EMERGENCY ROOM VISIT	25.00	024
025	INTERMED EMERGENCY ROOM VISIT	30.00	025
026	LIMITED CONSULTATION	38.60*	026
027	EXTENSIVE CONSULTATION	50.00	027
028	COMPREHENSIVE CONSULTATION	75.00	028
029	PSYCHOTHERAPY-ONE HOUR	50.00	029
030	PSYCHOTHERAPY-HALF HOUR	25.00	030
031	CHIROPRACTIC OFFICE VISIT	15.00	031
032	INITIAL PHYSIOTHERAPY	14.30*	032
033	F/U PODIATRIC OFFICE VISIT	17.10	033
034	ELECTROCARDIOGRAM (EKG)	25.00	034
035	EKG-INTERPRET.REPORT ONLY	7.50	035
036	ARTERIAL BLOOD GAS STUDY	71.40*	036
037	ELECTROENCEPHALOGRAM (EEG)	16.00	037
038	CHEMOTHERAPY	3.00	038
039	COLLECTION OF SPECIMENS	17.70*	039
040	DEBRIDEMENT OF NAILS	25.00	040
041	SKIN BIOPSY	21.70*	041
042	CHEMOCAUTERY	\$64.00*	042
043	RADICAL MASTECTOMY	1124.60*	043
044	OPEN REDUCTION OF FRACTURE	20.00	044
045	ARTHROCENTESIS-MAJOR JOINT	20.00	045
046	ARTHROTOMY	2000.00	046
047	ARTHROPLASTY-REPAIR OF HIP	20.00	047
048	NEEDLE PUNCTURE OF BURSA	178.20*	048
049	BRONCHOSCOPY	50.00*	049
050	THORACENTESIS		050

1979 PREVAILING CHARGE SUMMARY DATA			GROUP HEALTH INCORPORATED		FLORIDA	
PROCEDURE DESCRIPTION			COMBINED	LOCALITY	DESIGNATION	
				SINGLE		
051	CATHERIZATION OF HEART			641.70*		051
052	INSERTION OF PACEMAKER			1200.00		052
053	PARTIAL COLECTOMY			1000.00*		053
054	APPENDICETOMY			465.90*		054
055	SIGMOIDOSCOPY			35.00		055
056	HEMORRHOIDECTOMY			427.80*		056
057	CHOLECYSTECTOMY			855.60*		057
058	REPAIR HERNIA			427.80*		058
059	DIAGNOSTIC CYSTOURETHROSCOPY			52.20*		059
060	DILATION OF URETHRA			21.30*		060
061	PROSTATECTOMY			923.80*		061
062	ELECTROSECTION-PROSTATE (TUR)			962.50		062
063	HYSTERECTOMY					063
064	INITIAL COMPLETE EYE EXAM			35.00		064
065	COMPREHENSIVE EYE EXAM			40.00		065
066	EYE EXAM WITH TONOMETRY			16.40*		066
067	EXTRACTION OF LENS			784.30*		067
068	CHEST X-RAY, SINGLE VIEW			25.00		068
069	CHEST X-RAY, TWO VIEWS			28.50*		069
070	X-RAY SPINE			55.00		070
071	X-RAY HIP			35.00		071
072	X-RAY UPPER GI TRACT			27.00		072
073	X-RAY COLON			64.10*		073
074	RADIATION THERAPY-LOW VOLT			19.10*		074
075	RADIATION THERAPY-SUPER VOLT			20.00		075
076	RADIATION THERAPY-MEGAVOLT			16.80*		076
077	CAT SCAN - HEAD			112.50		077
078	CAT SCAN-HEAD, INTERPRET ONLY			34.00		078
079	THREE CHEMISTRY TESTS			10.50*		079
080	TWELVE CHEMISTRY TESTS			15.00		080
081	CULTURE-OTHER THAN BLOOD			15.00		081
082	HEMOGLOBIN			5.00		082
083	AUTOMATED BLOOD COUNT			10.00		083
084	WHITE CELL COUNT			5.00		084
085	COMPLETE BLOOD COUNT (CBC)			10.00		085
086	CHOLESTEROL TEST			6.00		086
087	FLOCCULATION TEST					087
088	HEMATOCRIT			5.00		088
089	PLATELET COUNT (REES-ECKER)			6.00		089
090	POTASSIUM TEST			8.00		090
091	PROTHROMBIN			7.00		091
092	SEDIMENTATION RATE			7.00		092
093	BLOOD SUGAR			7.00		093
094	BUN-UREA, NITROGEN			8.00		094
095	URIC ACID			8.00		095
096	FECES-OCCULT BLOOD			5.00		096
097	PAP TEST			11.00		097
098	ROUTINE URINALYSIS			5.00		098
099	CHEMICAL URINALYSIS			3.00		099
100	PATHOLOGY-THREE SPECIMENS			20.00		100

GEORGIA

GEORGIA



Four Localities (by counties)
 (For more locality information
 see Appendix A)

1979 PREVAILING CHARGE SUMMARY DATA

GEORGIA

PRUDENTIAL INSURANCE COMPANY

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

01

02

03

04

01

02

03

04

001 INITIAL BRIEF OFFICE VISIT	35.00	20.00	21.40*	15.00	35.00*	21.40*	20.00	25.00	001
002 INITIAL LIMITED OFFICE VISIT					35.00*	21.40*	20.00	25.00	002
003 INIT INTERMED OFFICE VISIT					35.00*	21.40*	20.00	25.00	003
004 INIT COMP OFFICE VISIT	35.00	60.00	35.00	25.00	75.00*	49.90*	55.00	60.00	004
005 MINIMAL F/U OFFICE VISIT	10.00*	10.00*	10.00*	7.10*	14.30*	14.30*	11.40*	10.00*	005
006 BRIEF F/U OFFICE VISIT	10.00*	10.00*	10.00*	7.10*	14.30*	14.30*	11.40*	10.00*	006
007 LIMITED F/U OFFICE VISIT	10.00*	10.00*	10.00*	7.10*	14.30*	14.30*	11.40*	10.00*	007
008 INTERMED F/U OFFICE VISIT	10.00*	10.00	10.00*	24.00	14.30*	14.30*	11.40*	10.00*	008
009 EXTENDED F/U OFFICE VISIT	41.00	30.00	28.00*	24.00	42.80*	42.80*	35.70*	21.40*	009
010 COMPLETE F/U OFFICE VISIT	41.00	30.00	28.00*	24.00	42.80*	42.80*	35.70*	21.40*	010
011 BRIEF F/U HOME VISIT	15.40*	14.30*	17.10*	14.30*	17.10*	21.40*	20.00*	14.30*	011
012 LIMITED F/U HOME VISIT					17.10*	21.40*	20.00*	14.30*	012
013 INTERMEDIATE F/U HOME VISIT	15.40*	14.30*	17.10*	14.30*	17.10*	21.40*	20.00*	14.30*	013
014 EXTENDED CARE FACILITY VISIT					14.30*	10.20*	11.40*	10.00*	014
015 BRIEF F/U NURSING HOME VISIT	10.00*	10.00*	10.00*	7.10*	14.30*	14.30*	11.40*	10.00*	015
016 INITIAL BRIEF HOSPITAL VISIT	35.70*	35.00	35.70*	28.50*	50.00*	49.90*	35.70*	35.70*	016
017 INIT INTERMED HOSPITAL VISIT					50.00*	49.90*	35.70*	35.70*	017
018 INITIAL COMP HOSPITAL VISIT	55.00	57.00*	49.90*	40.00	75.00*	64.20*	57.00*	49.90*	018
019 BRIEF F/U HOSPITAL VISIT	14.30*	14.30*	11.40*	11.40*	14.30*	14.30*	14.30*	13.70*	019
020 LIMITED F/U HOSPITAL VISIT	14.30*	14.30*	11.40*	11.40*	14.30*	14.30*	14.30*	13.70*	020
021 INTERMED F/U HOSPITAL VISIT	14.30*	14.30*	11.40*	11.40*	14.30*	14.30*	14.30*	13.70*	021
022 EXTENDED F/U HOSPITAL VISIT					14.30*	14.30*	14.30*	13.70*	022
023 BRIEF EMERGENCY ROOM VISIT					21.40*	21.40*	15.00*	17.10*	023
024 LIMITED EMERGENCY ROOM VISIT					21.40*	21.40*	15.00*	17.10*	024
025 INTERMED EMERGENCY ROOM VISIT	25.00*	25.00*	25.00*	15.00*	33.30*	32.50	30.00	33.30*	025
026 LIMITED CONSULTATION					57.00*	49.90*	42.80*	42.80*	026
027 EXTENSIVE CONSULTATION					75.00*	70.20*	50.80*	49.00*	027
028 COMPREHENSIVE CONSULTATION					50.00	50.00	60.00	50.00	028
029 PSYCHOTHERAPY-ONE HOUR					30.00	26.25	30.00	30.00	029
030 PSYCHOTHERAPY-HALF HOUR					8.90	10.30*	10.00	10.00	030
031 CHIROPRACTIC OFFICE VISIT	10.00	8.10*	8.00*	8.50*	14.60*	14.60*	14.60*	14.60*	031
032 INITIAL PHYSIOTHERAPY					14.30*	11.40*	11.00	12.80*	032
033 F/U PODIATRIC OFFICE VISIT					20.00	21.40*	20.00	21.40	033
034 ELECTROCARDIOGRAM (EKG)	20.00	21.40*	20.00*	20.00	8.60*	6.00	6.00	7.10*	034
035 EKG-INTERPRET-REPORT ONLY	7.50	8.60*	8.60	7.10*	25.00	25.50*	30.00	5.90*	035
036 ARTERIAL BLOOD GAS STUDY					55.00	57.00*	57.00*	57.00	036
037 ELECTROENCEPHALOGRAPH (EEG)					20.00	15.00	20.00	19.60*	037
038 CHEMOTHERAPY					5.00	6.70	6.00	6.70	038
039 COLLECTION OF SPECIMENS					18.00*	14.30*	15.00*	14.30*	039
040 DEBRIDEMENT OF NAILS					25.00*	21.40*	20.00	24.00	040
041 SKIN BIOPSY					15.00*	19.50*	14.30*	14.30*	041
042 CHEMOCAUTERY					880.00	700.00	775.00	765.00	042
043 RADICAL MASTECTOMY					713.00*	798.60*	560.00	713.00*	043
044 OPEN REDUCTION OF FRACTURE					15.50	21.40	17.00	17.00	044
045 ARTHROCENTESIS-MAJOR JOINT					15.00	17.10	15.00	17.00	045
046 ARTHROTOMY	15.00	15.00	10.00	10.00	713.00*	713.00*	900.00	750.00*	046
047 ARTHROPLASTY-REPAIR OF HIP					20.00	17.10*	14.30*	12.00	047
048 NEEDLE PUNCTURE OF BURSA					150.00*	150.00*	128.30*	128.30*	048
049 BRONCHOSCOPY					35.00	35.00	30.00	35.00	049
050 THORACENTESIS									050

1979 PREVAILING CHARGE SUMMARY DATA

PRUDENTIAL INSURANCE COMPANY

GEORGIA

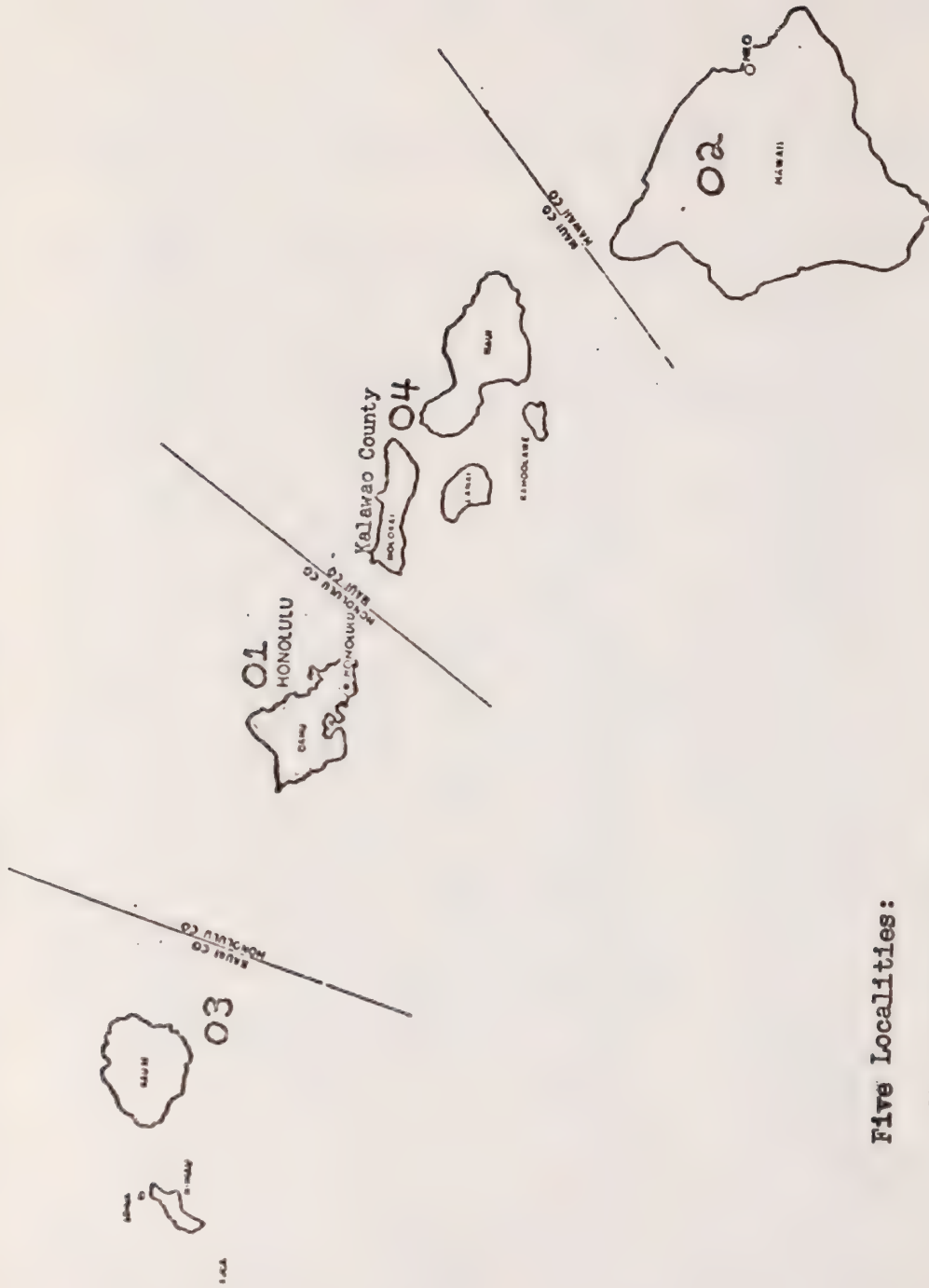
LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	04	01	02	03	04
051 CATHETERIZATION OF HEART					450.00	512.30	450.00	450.00
052 INSERTION OF PACEMAKER					734.40*	734.40*	734.40*	734.40*
053 PARTIAL COLECTOMY					850.00	684.50*	570.40*	684.50*
054 APPENDECTOMY					350.00	427.80	350.00	330.00
055 SIGMOIDOSCOPY	25.00*	17.10*	21.40*	21.40*	30.00	28.50*	28.50*	25.00*
056 HEMORRHOIDECTOMY					300.00	270.00	300.00	300.00
057 CHOLECYSTECTOMY					570.40*	513.40*	427.80*	427.80*
058 REPAIR HERNIA					385.00*	320.90*	342.20*	325.00
059 DIAGNOSTIC CYSTOURETHROSCOPY	42.80	42.80*	42.80*	42.80*	49.90*	42.80*	42.80*	42.80*
060 DILATION OF URETHRA					14.30*	14.30*	14.30*	14.30*
061 PROSTATECTOMY					641.70*	713.00*	570.40*	641.70*
062 ELECTROSECTION-PROSTATE (TUR)	690.00*	700.00*	700.00*	713.00*	713.00*	700.00*	670.20*	534.80*
063 HYSTERECTOMY					641.70*	641.70*	641.70*	641.70*
064 INITIAL COMPLETE EYE EXAM					24.00	21.40*	22.80*	22.80*
065 COMPREHENSIVE EYE EXAM					24.00	21.40*	21.40*	22.80*
066 EYE EXAM WITH TONOMETRY					11.00	21.40*	21.40*	22.80*
067 EXTRACTION OF LENS					627.40*	606.10*	570.40*	570.40*
068 CHEST X-RAY, SINGLE VIEW	630.20*	620.30*	620.30*	620.30*	22.00	20.00	17.10*	17.80*
069 CHEST X-RAY, TWO VIEWS	17.10	20.00	18.00	18.00	22.00	21.00	21.40*	12.00
070 X-RAY SPINE	22.00	18.75	21.40*	21.40	40.00	35.70*	49.40	50.00
071 X-RAY HIP					20.00	28.50*	24.20*	29.50
072 X-RAY UPPER GI TRACT	45.00	45.00*	45.00	45.00	49.90	53.50*	49.90*	53.50*
073 X-RAY COLON					42.60	42.80*	42.80*	52.80*
074 RADIATION THERAPY-LOW VOLT	24.10	24.10	24.10	24.10	23.70	23.80*	23.70*	24.10
075 RADIATION THERAPY-SUPER VOLT	18.20*	18.20*	18.90*	18.20*	28.30	35.00	32.40*	35.00
076 RADIATION THERAPY-MEGAVOLT					31.20	31.20	31.20*	31.20
077 CAT SCAN - HEAD					150.00	150.00	150.00	150.00
078 CAT SCAN-HEAD, INTERPRET ONLY					50.00	50.00	50.00	50.00
079 THREE CHEMISTRY TESTS					23.00	23.00	22.00	10.50
080 TWELVE CHEMISTRY TESTS					20.00	20.00	7.00	15.00
081 CULTURE-OTHER THAN BLOOD					10.00	14.00	12.00	10.00
082 HEMOGLOBIN					4.00	4.00	3.00	3.00
083 AUTOMATED BLOOD COUNT					10.00	10.00	8.00	8.00
084 WHITE CELL COUNT					4.00	5.00	3.00	4.00
085 COMPLETE BLOOD COUNT (CBC)					10.00	10.00	8.00	8.00
086 CHOLESTEROL TEST					7.50	8.00	6.00	7.00
087 FLOCCULATION TEST					5.50	5.00	10.00	6.00
088 HEMATOCRIT					3.75	4.00	3.00	3.00
089 PLATELET COUNT (REES-ECKER)					6.00	6.00	6.00	6.00
090 POTASSIUM TEST					7.00	8.00	7.00	8.00
091 PROTHROMBIN					7.50	7.00	6.00	6.00
092 SEDIMENTATION RATE					6.00	4.00	5.00	6.00
093 BLOOD SUGAR					7.00	8.00	6.00	6.00
094 BUN-UREA-NITROGEN					6.00	8.00	7.00	6.00
095 URIC ACID					7.00	8.00	7.00	6.50
096 FECES-OCCULT BLOOD					5.00	2.50	5.00	3.00
097 PAP TEST					9.00	7.00	8.00	10.00
098 ROUTINE URINALYSIS					5.00	5.00	4.00	4.00
099 CHEMICAL URINALYSIS					5.00	5.00	4.00	4.00
100 PATHOLOGY-THREE SPECIMENS					20.00	20.00	20.00	20.00

[illegible]

99 - Guam - all Part B Claims processed
by Aetna-Hawaii

HAWAII



Five Localities:

- 01 - Honolulu County
- 02 - Hawaii County
- 03 - Maui County
- 04 - Kauai County
- 99 - Guam

1979 PREVAILING CHARGE SUMMARY DATA

AETNA LIFE AND CASUALTY

HAWAII

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

01

02

03

04

99

01

02

03

04

99

001 INITIAL BRIEF OFFICE VISIT

002 INITIAL LIMITED OFFICE VISIT

003 INIT INTERMED OFFICE VISIT

004 INIT COMP OFFICE VISIT

005 MINIMAL F/U OFFICE VISIT

006 BRIEF F/U OFFICE VISIT

007 LIMITED F/U OFFICE VISIT

008 INTERMED F/U OFFICE VISIT

009 EXTENDED F/U OFFICE VISIT

010 COMPLETE F/U OFFICE VISIT

011 BRIEF F/U HOME VISIT

012 LIMITED F/U HOME VISIT

013 INTERMDIATE F/U HOME VISIT

014 EXTENDED CARE FACILITY VISIT

015 BRIEF F/U NURSING HOME VISIT

016 INITIAL BRIEF HOSPITAL VISIT

017 INIT INTERMED HOSPITAL VISIT

018 INITIAL COMP HOSPITAL VISIT

019 BRIEF F/U HOSPITAL VISIT

020 LIMITED F/U HOSPITAL VISIT

021 INTERMED F/U HOSPITAL VISIT

022 EXTENDED F/U HOSPITAL VISIT

023 BRIEF EMERGENCY ROOM VISIT

024 LIMITED EMERGENCY ROOM VISIT

025 INTERMED EMERGENCY ROOM VISIT

026 LIMITED CONSULTATION

027 EXTENSIVE CONSULTATION

028 COMPREHENSIVE CONSULTATION

029 PSYCHOTHERAPY-ONE HOUR

030 PSYCHOTHERAPY-HALF HOUR

031 CHIROPRACTIC OFFICE VISIT

032 INITIAL PHYSIOTHERAPY

033 F/U PODIATRIC OFFICE VISIT

034 ELECTROCARDIOGRAM (EKG)

035 EKG-INTERPRET, REPORT ONLY

036 ARTERIAL BLOOD GAS STUDY

037 ELECTROENCEPHALOGRAM (EEG)

038 CHEMOTHERAPY

039 COLLECTION OF SPECIMENS

040 DEBRIDEMENT OF NAILS

041 SKIN BIOPSY

042 CHEMOCAUTERY

043 RADICAL MASTECTOMY

044 OPEN REDUCTION OF FRACTURE

045 ARTHROCENTESIS-MAJOR JOINT

046 ARTHROTOMY

047 ARTHROPLASTY-REPAIR OF HIP

048 NEEDLE PUNCTURE OF BURSA

049 BRONCHOSCOPY

050 THORACENTESIS

17.10*

31.20

46.60*

57.00*

8.60*

11.40*

17.10*

20.80

31.20

47.50*

21.20

31.80

31.80

11.40*

11.40*

35.60*

57.00*

71.40*

14.98

22.80*

33.10*

38.25*

28.30*

30.40*

70.80*

44.10*

66.30*

79.90*

57.60*

31.20

9.50*

13.32

8.11

28.50*

8.60*

79.10

64.90*

20.90*

3.00

15.00

36.40

26.83

912.60*

912.60*

34.20*

28.50

1512.50

158.25*

34.20*

15.00*

31.20

35.00*

59.40

6.80*

10.00*

15.00*

20.80

21.00*

47.50*

21.60

29.10

29.10

11.40*

9.90

30.00*

49.90*

65.52

12.48

22.80*

38.25*

27.40*

28.70*

50.00

41.00*

61.50*

69.90*

49.50*

24.70*

10.90*

12.00

13.32

8.11

30.00*

8.60*

69.30

74.20

25.70*

3.00

20.80

25.70*

15.00

25.70*

18.90*

912.60*

912.60*

33.00*

26.70*

1487.50

1487.50

20.80

153.00

26.50*

31.60*

15.00*

26.21

43.10*

49.90*

8.10*

10.00*

13.80*

20.00*

30.00*

47.50*

21.20

31.80

31.80

10.40

9.70

30.00*

49.90*

65.52

17.89*

22.80*

38.25*

22.70*

28.70*

63.60*

42.00*

60.40*

69.90*

51.40*

28.30*

10.70*

13.32

9.30

22.30*

8.60*

67.90

74.20

24.25

3.00

19.40

28.50*

22.80*

912.60*

758.60*

29.70*

24.00*

1462.50

1462.50

20.80

150.60*

31.20*

29.10

679.00

880.00

33.00

22.00

1375.00

19.40

145.50

29.10

1979 PREVAILING CHARGE SUMMARY DATA AETNA LIFE AND CASUALTY

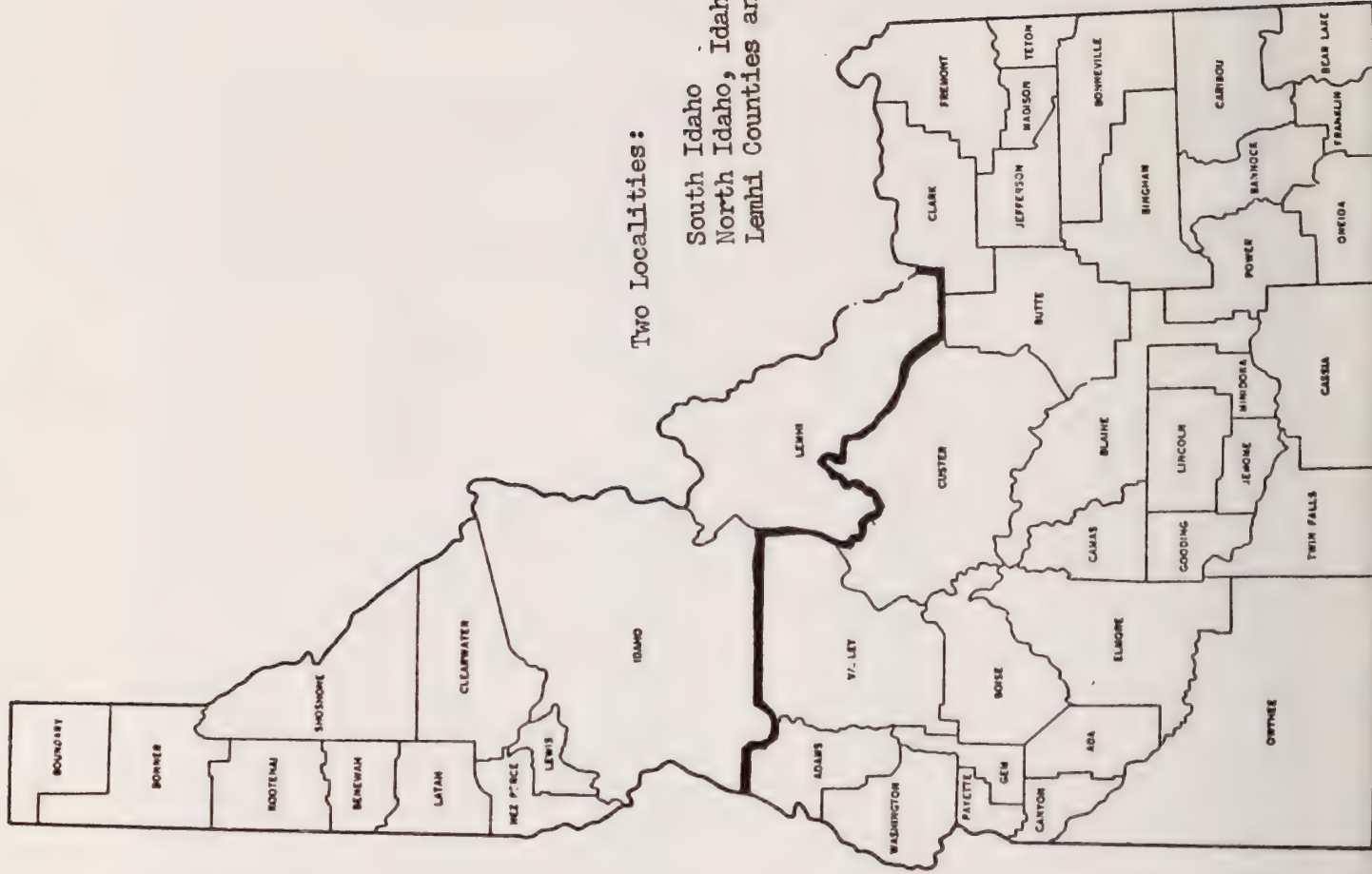
HAWAII

AETNA LIFE AND CASUALTY

LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
PROCEDURE DESCRIPTION	01	02	03	04	99
051 CATHETERIZATION OF HEART	533.80*	481.50	517.50	517.50	517.50
052 INSERTION OF PACEMAKER	998.20*	1070.00	1150.00	1150.00	1150.00
053 PARTIAL COLECTOMY	912.60*	698.88*	798.60*	830.50*	776.00
054 APPENDECTOMY	456.30*	342.10*	357.60*	456.30*	388.00
055 SIGMOIDOSCOPY	34.20*	27.90*	30.00*	30.00*	26.50*
056 HEMORRHOIDECTOMY	342.10*	283.00*	312.00	299.50*	291.00
057 CHOLECYSTECTOMY	684.50*	524.16*	633.10*	622.90*	565.90*
058 REPAIR HERNIA	399.30*	305.76*	360.10*	349.40*	330.10*
059 DIAGNOSTIC CYSTOURETHROSCOPY	79.90*	79.90*	52.00	85.80*	83.00*
060 DILATION OF URETHRA	35.88	35.88	31.50	31.20*	30.30
061 PROSTATECTOMY	798.60*	798.60*	840.00	760.00	808.00
062 ELECTROSECTION-PROSTATE (TUR)	855.60*	802.20*	840.00	698.70*	707.30*
063 HYSTERECTOMY	798.60*	648.75*	754.90*	660.20*	833.00*
064 INITIAL COMPLETE EYE EXAM	33.28	35.60*	27.90*	34.20*	35.60*
065 COMPREHENSIVE EYE EXAM	33.28	35.60*	27.90*	34.20*	35.60*
066 EYE EXAM WITH TONOMETRY	10.40*	10.40*	10.40*	10.40*	14.60*
067 EXTRACTION OF LENS	855.60*	707.40*	741.40*	798.60*	707.40*
068 CHEST X-RAY-SINGLE VIEW	20.28	14.80*	19.20	19.76	19.20
069 CHEST X-RAY-TWO VIEWS	27.30	21.84*	26.70*	27.90	28.80
070 X-RAY SPINE	35.90*	29.02*	28.80	35.90	28.80
071 X-RAY HIP	36.50	29.02*	38.40	39.60	38.40
072 X-RAY UPPER GI TRACT	53.90*	51.30*	54.00	51.30*	45.60
073 X-RAY COLON	64.10*	53.10*	57.60	59.40	57.60
074 RADIATION THERAPY-LOW VOLT	58.40*	58.40*	48.00	49.50	48.00
075 RADIATION THERAPY-SUPER VOLT	27.00	24.30	27.00	28.80	28.80
076 RADIATION THERAPY-MEGAVOLT	36.00	32.40	38.40	39.60	38.40
077 CAT SCAN - HEAD	47.50	40.50	48.00	49.50	48.00
078 CAT SCAN-HEAD, INTERPRET ONLY	52.00	52.00	52.00	52.00	52.00
079 THREE CHEMISTRY TESTS	10.40	10.40	14.45	10.40	10.40
080 TWELVE CHEMISTRY TESTS	15.00	16.64	29.75	16.64	30.10
081 CULTURE-OTHER THAN BLOOD	12.50	7.80	12.50	8.32	12.50
082 HEMOGLOBIN	4.63	4.68	4.68	4.68	3.44
083 AUTOMATED BLOOD COUNT	7.02	6.46	5.10	6.46	5.16
084 WHITE CELL COUNT	4.99	4.86	4.86	4.86	3.44
085 COMPLETE BLOOD COUNT (CBC)	9.71	8.84	9.67	10.30	9.71
086 CHOLESTEROL TEST	8.79	8.32	8.32	8.11	8.32
087 FLOCCULATION TEST	7.48	7.48	5.10	7.48	7.48
088 HEMATOCRIT	5.20	4.00	4.68	4.68	3.44
089 PLATELET COUNT (REES-ECKER)	6.24	6.24	6.24	9.36	6.24
090 POTASSIUM TEST	10.61	8.84	9.71	9.71	9.71
091 PROTHROMBIN	8.35	7.28	5.95	9.36	6.02
092 SEDIMENTATION RATE	6.55	7.28	6.55	5.20	6.55
093 BLOOD SUGAR	8.84	8.32	8.74	9.36	8.00
094 BUN-UREA,NITROGEN	8.32	8.32	8.32	7.28	8.32
095 URIC ACID	8.32	7.28	8.74	9.36	8.32
096 FECES-OCULT BLOOD	3.64	4.16	3.74	3.74	3.74
097 PAP TEST	8.32	7.02	7.28	7.28	7.28
098 ROUTINE URINALYSIS	8.32	7.02	7.28	7.28	7.28
099 CHEMICAL URINALYSIS	4.68	4.47	4.37	4.68	4.68
100 PATHOLOGY-THREE SPECIMENS	3.75	2.91	2.91	3.54	2.58

IDAHO

IDAHO



Two Localities:

South Idaho
North Idaho, Idaho and
Lemhi Counties and points north

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

SOUTH

NORTH

SOUTH

NORTH

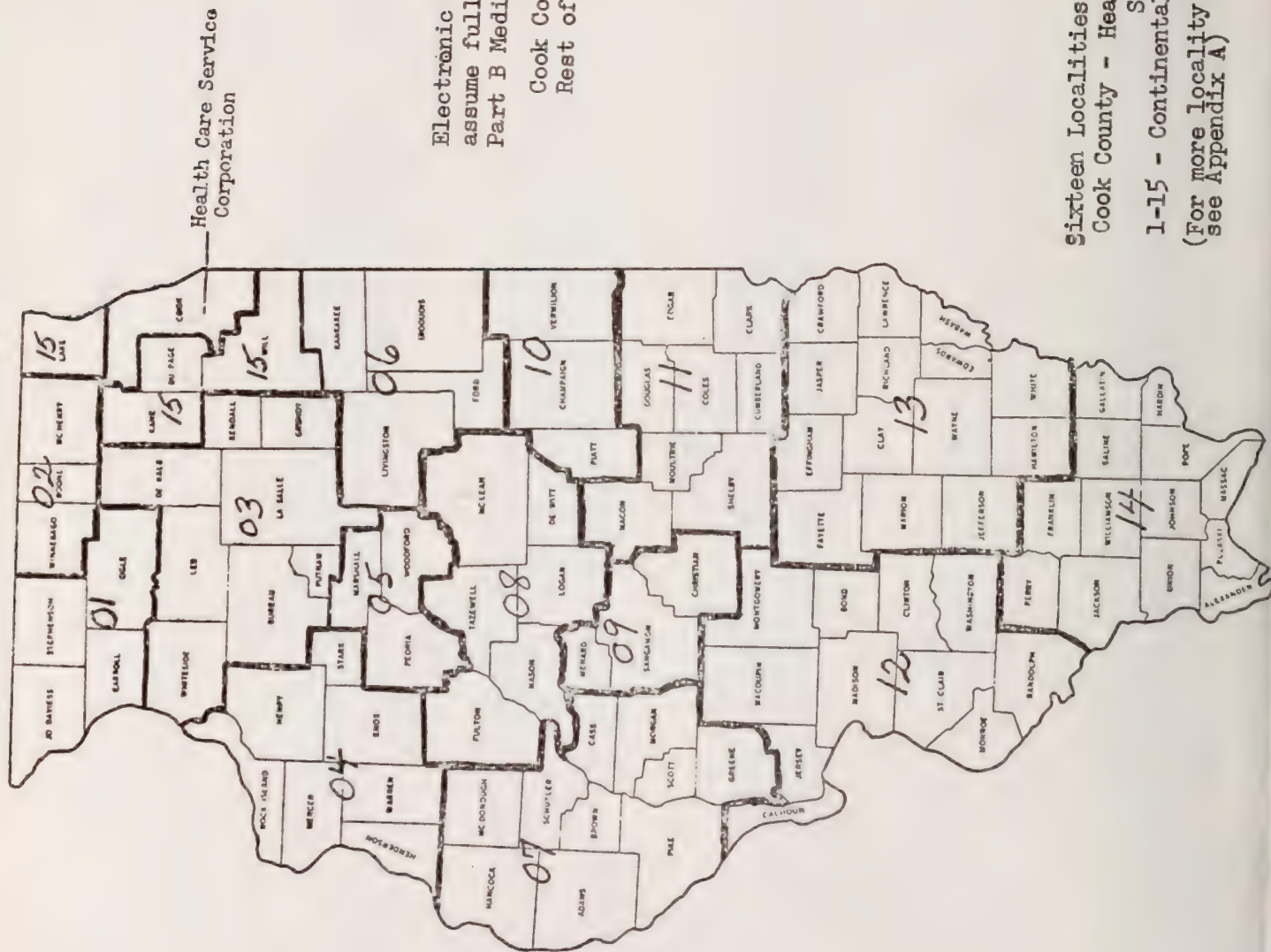
001	INITIAL BRIEF OFFICE VISIT			15.00		16.00*	001
002	INITIAL LIMITED OFFICE VISIT	25.00*	25.50	35.60*		42.00	002
003	INIT INTERMED OFFICE VISIT			35.60*		42.00	003
004	INIT COMP OFFICE VISIT	40.00*	35.00	49.90*		56.00*	004
005	MINIMAL F/U OFFICE VISIT	5.70*	6.80*	7.20*		6.80*	005
006	BRIEF F/U OFFICE VISIT	8.60*	8.60*	11.40*		10.70*	006
007	LIMITED F/U OFFICE VISIT	11.40*	11.40*	15.00*		11.20*	007
008	INTERMED F/U OFFICE VISIT	12.90*	15.20*	17.70*		17.00	008
009	EXTENDED F/U OFFICE VISIT	23.20*	22.80*	45.40*		25.00	009
010	COMPLETE F/U OFFICE VISIT	24.90*	32.30*	47.40*		43.00	010
011	BRIEF F/U HOME VISIT	15.70*	17.00	15.00*		17.00	011
012	LIMITED F/U HOME VISIT			25.00		25.50	012
013	INTERMEDIATE F/U HOME VISIT	22.00	22.00	16.70*			013
014	EXTENDED CARE FACILITY VISIT			10.70*		10.70	014
015	BRIEF F/U NURSING HOME VISIT	8.60*	8.60*	11.40*		10.70*	015
016	INITIAL BRIEF HOSPITAL VISIT	28.50*	26.00	35.60*		40.00	016
017	INIT INTERMED HOSPITAL VISIT			49.90*		42.80	017
018	INITIAL COMP HOSPITAL VISIT	40.00*	49.90*	49.90*		49.90*	018
019	BRIEF F/U HOSPITAL VISIT	8.60*	8.60*	10.70*		10.70*	019
020	LIMITED F/U HOSPITAL VISIT	14.30*	15.70*	20.00*		15.70*	020
021	INTERMED F/U HOSPITAL VISIT	21.90*	19.00*	24.30*		24.00	021
022	EXTENDED F/U HOSPITAL VISIT			27.80*		30.00	022
023	BRIEF EMERGENCY ROOM VISIT			12.60*		12.80	023
024	LIMITED EMERGENCY ROOM VISIT			16.10*		17.70	024
025	INTERMED EMERGENCY ROOM VISIT			25.50*		30.00	025
026	LIMITED CONSULTATION	25.00*	25.50	35.60*		35.00	026
027	EXTENSIVE CONSULTATION			49.90*		42.50	027
028	COMPREHENSIVE CONSULTATION			57.10*		57.10*	028
029	PSYCHOTHERAPY-ONE HOUR			33.50*		34.00*	029
030	PSYCHOTHERAPY-HALF HOUR						030
031	CHIROPRACTIC OFFICE VISIT	8.10*	8.60*	8.90*		8.60	031
032	INITIAL PHYSIOTHERAPY						032
033	F/U PODIATRIC OFFICE VISIT						033
034	ELECTROCARDIOGRAM (EXC)	21.40*	21.40*	25.00		25.50	034
035	EKG-INTERPRET, REPORT ONLY	7.50*	10.00*	15.00		11.20*	035
036	ARTERIAL BLOOD GAS STUDY			7.60*		8.80*	036
037	ELECTROENCEPHALOGRAM (EEG)			55.40*			037
038	CHEMOTHERAPY						038
039	COLLECTION OF SPECIMENS			4.50*		4.50	039
040	DEBRIDEMENT OF NAILS			10.90*		10.90	040
041	SKIN BIOPSY			22.00		22.50	041
042	CHEMOCAUTERY			12.80		12.80	042
043	RADICAL MASTECTOMY			508.50*		508.50*	043
044	OPEN REDUCTION OF FRACTURE			684.70*		684.70*	044
045	ARTHROCENTESIS-MAJOR JOINT			15.70*			045
046	ARTHROTOMY			15.00*		14.30*	046
047	ARTHROPLASTY-REPAIR OF HIP			1266.80*		1264.30*	047
048	NEEDLE PUNCTURE OF BURSA			15.00		20.70*	048
049	BRONCHOSCOPY			135.60*		135.60*	049
050	THORACENTESIS	12.40	14.30*	35.00		23.00	050

1979 PREVAILING CHARGE SUMMARY DATA EQUITABLE LIFE ASSURANCE SOCIETY IDAHO

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	SOUTH	NORTH	SOUTH	NORTH
051 CATHETERIZATION OF HEART				847.70
052 INSERTION OF PACEMAKER			713.20*	641.90*
053 PARTIAL COLECTOMY			329.10*	300.30*
054 APPENDECTOMY			21.40*	29.50*
055 SIGMOIDOSCOPY		27.10*	247.50*	221.30*
056 HEMORRHOIDECTOMY	21.40*		499.20*	496.00
057 CHOLECYSTECTOMY			285.30*	285.30
058 REPAIR HERNIA			50.00	44.00
059 DIAGNOSTIC CYSTOURETHROSCOPY	49.90*		14.00	14.10
060 DILATION OF URETHRA			692.90*	590.00*
061 PROSTATECTOMY			570.60*	570.60*
062 ELECTROSECTION-PROSTATE (TUR)	570.60*		26.40*	28.00
063 HYSTERECTOMY			26.40*	28.00
064 INITIAL COMPLETE EYE EXAM				
065 COMPREHENSIVE EYE EXAM				
066 EYE EXAM WITH TONOMETRY				
067 EXTRACTION OF LENS				
068 CHEST X-RAY, SINGLE VIEW		13.90	535.00*	713.20*
069 CHEST X-RAY, TWO VIEWS		20.00*	20.00	20.00
070 X-RAY SPINE			25.00	24.00
071 X-RAY HIP			33.50	33.50
072 X-RAY UPPER GI TRACT			30.00	30.00
073 X-RAY COLON			53.00	53.00
074 RADIATION THERAPY-LOW VOLT			54.00	54.00
075 RADIATION THERAPY-SUPER VOLT			20.00	
076 RADIATION THERAPY-MEGAVOLT				
077 CAT SCAN - HEAD				
078 CAT SCAN-HEAD, INTERPRET ONLY		44.20*	250.00	
079 THREE CHEMISTRY TESTS				
080 TWELVE CHEMISTRY TESTS				
081 CULTURE-OTHER THAN BLOOD				
082 HEMOGLOBIN			8.00	8.00
083 AUTOMATED BLOOD COUNT			4.00	4.00
084 WHITE CELL COUNT				
085 COMPLETE BLOOD COUNT (CBC)			4.00	4.00
086 CHOLESTEROL TEST			9.50	9.50
087 FLOCCULATION TEST			7.70	6.00
088 HEMATOCRIT			4.00	4.00
089 PLATELET COUNT (REES-ECKER)			3.00	3.00
090 POTASSIUM TEST			6.40	6.40
091 PROTHROMBIN			7.60	7.60
092 SEDIMENTATION RATE			8.00	8.00
093 BLOOD SUGAR			4.50	4.50
094 BUN-UREA,NITROGEN			7.50	7.50
095 URIC ACID			8.00	8.00
096 FECES-OCULT BLOOD			8.00	8.00
097 PAP TEST			4.00	4.00
098 ROUTINE URINALYSIS			8.80	8.80
099 CHEMICAL URINALYSIS			4.50	4.50
100 PATHOLOGY-THREE SPECIMENS			5.00	5.00
			14.00	14.00

ILLINOIS

ILLINOIS



Electronic Data Systems Federal will assume full responsibility for paying Part B Medicare claims in:

Cook Co. by March 31, 1979
Rest of state by June 30, 1979

Sixteen Localities:
Cook County - Health Care Service Corporation
1-15 - Continental Casualty Co.
(For more locality information see Appendix A)

1979 PREVAILING CHARGE SUMMARY DATA HEALTH CARE SERVICE CORPORATION ILLINOIS

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE	LOCALITY DESIGNATION FOR SPECIALIST	COOK CO	COOK CO
001 INITIAL BRIEF OFFICE VISIT			25.00	14.30*
002 INITIAL LIMITED OFFICE VISIT				40.00
003 INIT INTERMED OFFICE VISIT				30.00
004 INIT COMP OFFICE VISIT			25.00	40.00
005 MINIMAL F/U OFFICE VISIT			11.30*	14.30*
006 BRIEF F/U OFFICE VISIT			11.30*	14.30*
007 LIMITED F/U OFFICE VISIT			11.30*	14.30*
008 INTERMED F/U OFFICE VISIT			11.30*	30.00
009 EXTENDED F/U OFFICE VISIT			21.30*	30.00
010 COMPLETE F/U OFFICE VISIT			25.00	40.00
011 BRIEF F/U HOME VISIT			20.00	25.00
012 LIMITED F/U HOME VISIT				25.00
013 INTERMEDIATE F/U HOME VISIT			20.00	30.00
014 EXTENDED CARE FACILITY VISIT				15.00*
015 BRIEF F/U NURSING HOME VISIT			11.30*	14.30*
016 INITIAL BRIEF HOSPITAL VISIT			35.00	49.90*
017 INIT INTERMED HOSPITAL VISIT				49.90*
018 INITIAL COMP HOSPITAL VISIT			50.00	71.30*
019 BRIEF F/U HOSPITAL VISIT			14.30*	20.00
020 LIMITED F/U HOSPITAL VISIT			14.30*	20.00
021 INTERMED F/U HOSPITAL VISIT				20.00
022 EXTENDED F/U HOSPITAL VISIT				30.00
023 BRIEF EMERGENCY ROOM VISIT				25.00
024 LIMITED EMERGENCY ROOM VISIT				25.00
025 INTERMED EMERGENCY ROOM VISIT			49.90*	49.90*
026 LIMITED CONSULTATION				71.30*
027 EXTENSIVE CONSULTATION				71.30*
028 COMPREHENSIVE CONSULTATION				49.90
029 PSYCHOTHERAPY-ONE HOUR				28.50
030 PSYCHOTHERAPY-HALF HOUR				10.00*
031 CHIROPRACTIC OFFICE VISIT				60.00
032 INITIAL PHYSIOTHERAPY				13.00
033 F/U PODIATRIC OFFICE VISIT				20.00
034 ELECTROCARDIOGRAM (EKG)			20.00	8.00*
035 EKG-INTERPRET. REPORT ONLY			8.00*	20.00
036 ARTERIAL BLOOD GAS STUDY				20.00
037 ELECTROENCEPHALOGRAM (EEG)				49.90*
038 CHEMOTHERAPY				20.00
039 COLLECTION OF SPECIMENS				3.00*
040 DEBRIDEMENT OF NAILS				15.00
041 SKIN BIOPSY				35.60*
042 CHEMOCAUTERY				40.00
043 RADICAL MASTECTOMY				855.60*
044 OPEN REDUCTION OF FRACTURE				1069.50*
045 ARTHROCENTESIS-MAJOR JOINT				25.00
046 ARTHROTOMY				25.00
047 ARTHROPLASTY-REPAIR OF HIP			20.00	1069.50*
048 NEEDLE PUNCTURE OF BURSA				49.90*
049 BRONCHOSCOPY				178.20*
050 THORACENTESIS				71.30*

1979 PREVAILING CHARGE SUMMARY DATA HEALTH CARE SERVICE CORPORATION ILLINOIS

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE	LOCALITY DESIGNATION FOR SPECIALIST
051 CATHETERIZATION OF HEART	COOK CO	COOK CO
052 INSERTION OF PACEMAKER		499.10*
053 PARTIAL COLECTOMY		1140.70*
054 APENDICECTOMY		1069.50*
055 SIGMOIDOSCOPY	35.60*	499.10*
056 HEMORRHOIDECTOMY		35.60*
057 CHOLECYSTECTOMY		427.80*
058 REPAIR HERNIA		713.00*
059 DIAGNOSTIC CYSTOURETHROSCOPY	50.00*	427.80
060 DILATION OF URETHRA		57.00*
061 PROSTATECTOMY		15.00
062 ELECTROSECTION-PROSTATE (TUR)	713.00*	900.00
063 HYSTERECTOMY		819.90*
064 INITIAL COMPLETE EYE EXAM		855.60
065 COMPREHENSIVE EYE EXAM		26.00
066 EYE EXAM WITH TONOMETRY		22.40
067 EXTRACTION OF LENS		14.30*
068 CHEST X-RAY, SINGLE VIEW	18.00*	850.00
069 CHEST X-RAY, TWO VIEWS	22.80*	18.90*
070 X-RAY SPINE		24.30*
071 X-RAY HIP		45.00
072 X-RAY UPPER GI TRACT	49.90*	30.00*
073 X-RAY COLON		49.90*
074 RADIATION THERAPY-LOW VOLT		49.90*
075 RADIATION THERAPY-SUPER VOLT		15.00
076 RADIATION THERAPY-MEGAVOLT		21.30*
077 CAT SCAN - HEAD		21.30*
078 CAT SCAN-HEAD, INTERPRET ONLY		150.00*
079 THREE CHEMISTRY TESTS		75.00
080 TWELVE CHEMISTRY TESTS		13.00*
081 CULTURE-OTHER THAN BLOOD		17.00*
082 HEMOGLOBIN		20.00
083 AUTOMATED BLOOD COUNT		4.00
084 WHITE CELL COUNT		10.00
085 COMPLETE BLOOD COUNT (CBC)		4.00
086 CHOLESTEROL TEST		10.00
087 FLOCCULATION TEST		8.00
088 HEMATOCRIT		6.00
089 PLATELET COUNT (REES-ECKER)		4.75
090 POTASSIUM TEST		6.00
091 PROTHROMBIN		7.00
092 SEDIMENTATION RATE		7.00
093 BLOOD SUGAR		5.00
094 BUN-UREA, NITROGEN		7.00
095 URIC ACID		7.75
096 FECES-OCCULT BLOOD		7.00
097 PAP TEST		5.00
098 ROUTINE URINALYSIS		11.00
099 CHEMICAL URINALYSIS		5.00
100 PATHOLOGY-THREE SPECIMENS.		20.00

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

	01	02	03	04	05	01	02	03	04	05
001 INITIAL BRIEF OFFICE VISIT	22.80*	22.80*	25.00	35.00	30.00	21.30*	28.50*	21.30*	28.50*	21.30*
002 INITIAL LIMITED OFFICE VISIT						30.00*	35.60*	25.00*	40.00	42.00
003 INIT INTERMED OFFICE VISIT	35.00*	15.00*	35.00*	49.10*	45.70*	40.00*	42.80*	40.00*	49.90*	35.60*
004 INIT COMP OFFICE VISIT	3.00	8.60*	2.00	3.00	2.00	5.70*	3.00	4.20*	2.00	4.20*
005 MINIMAL F/U OFFICE VISIT	7.10*	10.00*	8.60*	8.60*	10.00*	10.00*	11.30*	10.00*	11.30*	11.30*
006 BRIEF F/U OFFICE VISIT	13.00	15.00	14.00	11.00	13.00	12.00	16.00	12.00	15.00	18.00
007 LIMITED F/U OFFICE VISIT	12.00	12.00	10.00	25.00	10.50*	21.30*	13.00	12.00	21.30*	15.00*
008 INTERMED F/U OFFICE VISIT	17.10*	20.00	20.00	20.00	20.00	25.00	20.00	40.00	20.00	20.00*
009 EXTENDED F/U OFFICE VISIT	28.00*	28.00*	28.00*	28.00*	28.00*	45.00	42.80*	40.00	28.50*	28.00*
010 COMPLETE F/U OFFICE VISIT	11.30*	17.10*	14.30*	14.30*	14.30*	14.30*	15.00	15.00*	14.30*	20.00
011 BRIEF F/U HOME VISIT						14.50*	18.00	16.10*	18.00	17.60*
012 LIMITED F/U HOME VISIT						14.50*	18.00	16.10*	18.00	17.60*
013 INTERMEDIATE F/U HOME VISIT	25.00	25.00	25.00*	21.30*	25.00	27.60*	27.60*	27.60*	27.60*	27.60*
014 EXTENDED CARE FACILITY VISIT	7.10*	10.00	8.60	8.60*	10.00*	10.00	11.30*	10.00*	11.30*	11.30*
015 BRIEF F/U NURSING HOME VISIT	21.30*	21.30*	28.50*	30.00	21.30*	30.00*	35.60*	35.00	35.60	35.00*
016 INITIAL BRIEF HOSPITAL VISIT						40.00*	49.90*	45.00	40.00	42.00
017 INIT INTERMED HOSPITAL VISIT						40.00*	49.90*	45.00	40.00	45.00*
018 INITIAL COMP HOSPITAL VISIT	50.00	42.70*	50.00	50.00	50.00	55.10*	60.00	45.00	40.00	45.00*
019 BRIEF F/U HOSPITAL VISIT	8.60*	10.00*	10.00*	10.00*	10.00*	10.00*	14.30*	11.30*	11.30*	11.30*
020 LIMITED F/U HOSPITAL VISIT	15.00*	20.00	17.10*	20.00	20.00*	24.00	25.00	21.30*	25.00	24.00
021 INTERMED F/U HOSPITAL VISIT						20.00	45.00	20.00	20.00	20.00
022 EXTENDED F/U HOSPITAL VISIT						20.00	45.00	20.00	20.00	20.00
023 BRIEF EMERGENCY ROOM VISIT						19.40	25.20	20.60	22.20	22.20
024 LIMITED EMERGENCY ROOM VISIT						33.95	44.10	36.05	38.85	38.85
025 INTERMED EMERGENCY ROOM VISIT						7.25*	16.00	10.00	10.60*	14.80*
026 LIMITED CONSULTATION	17.00*	17.00*	17.00*	20.00	17.00*	25.00	25.00	25.00	25.00	25.00
027 EXTENSIVE CONSULTATION						40.00	49.90*	49.90*	35.60*	35.60*
028 COMPREHENSIVE CONSULTATION						49.90*	49.90*	50.00	49.90*	50.00*
029 PSYCHOTHERAPY-ONE HOUR						26.00	15.00*	45.00	21.30*	28.50*
030 PSYCHOTHERAPY-HALF HOUR						30.00	25.10*	28.50*	21.60*	25.00*
031 CHIROPRACTIC OFFICE VISIT	13.10*	34.20*	11.20*	13.10*	13.10*	7.10*	8.80*	10.00*	10.00	10.00
032 INITIAL PHYSIOTHERAPY						11.00	11.00	11.00	11.00	12.00
033 F/U PODIATRIC OFFICE VISIT						10.00*	11.30*	10.00*	10.00	11.30*
034 ELECTROCARDIOGRAM (EKG)	16.00	20.00	20.00	25.00	21.30*	18.00	20.00	16.50	25.00	21.30*
035 EKG-INTERPRET. REPORT ONLY	7.00	7.00	7.00	7.00	7.00	7.00	16.00	7.00	7.00	7.00
036 ARTERIAL BLOOD GAS STUDY						47.00	45.00	42.00	55.00	51.00
037 ELECTROENCEPHALOGRAPH (EEG)						16.00	16.00	16.00	16.00	16.00
038 CHEMOTHERAPY						19.40	25.20	20.60	22.20	22.20
039 COLLECTION OF SPECIMENS										
040 DEBRIDEMENT OF NAILS						18.90*	11.30*	15.00*	14.30*	20.00
041 SKIN BIOPSY						47.20*	20.00*	42.80*	28.50*	35.00*
042 CHEMOCAUTERY						24.00	24.00	24.00	24.00	24.00
043 RADICAL MASTECTOMY						598.90*	570.40*	677.30*	641.70*	570.40*
044 OPEN REDUCTION OF FRACTURE						900.00	855.60*	656.00*	793.60*	684.50*
045 ARTHROCENTESIS-MAJOR JOINT						40.00*	40.00*	30.40*	31.20*	40.00*
046 ARTHROTOMY						13.00	17.10*	10.00	18.00	10.00*
047 ARTHROPLASTY-REPAIR OF HIP	12.00	16.00	17.50	10.00	20.00	1729.20*	1212.10*	1729.20*	1729.20*	924.00*
048 NEEDLE PUNCTURE OF BURSA						10.00*	15.00	12.00*	15.00	15.00*
049 BRONCHOSCOPY						180.00	150.00*	142.60*	149.70*	142.60*
050 THORACENTESIS						38.50*	49.90*	49.90*	50.00*	49.90*

1979 PREVAILING CHARGE SUMMARY DATA CONTINENTAL CASUALTY COMPANY

ILLINOIS

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	04	05	01	02	03	04	05
051 CATHETERIZATION OF HEART						403.40*	520.00	403.40*	485.40*	361.20*
052 INSERTION OF PACEMAKER						1150.00	860.20*	1150.00	1150.00	1150.00
053 PARTIAL COLECTOMY						713.00*	713.00*	748.60*	798.60*	702.00
054 APPENDECTOMY						285.20*	355.50*	356.50*	356.50*	285.20*
055 Sigmoidoscopy	25.00*	35.00	25.00	35.60*	35.00	25.00	28.50*	35.00	35.00	35.60*
056 HEMORRHOIDECTOMY						320.80*	350.00	285.00*	299.50*	350.00
057 CHOLECYSTECTOMY						550.00	500.00	570.40*	565.00	513.40*
058 REPAIR HERNIA						350.50*	385.00*	356.50*	349.40*	356.50*
059 DIAGNOSTIC CYSTOURETHROSCOPY	44.50*	50.00	50.00	50.00	50.00	49.90*	40.00	50.00*	42.80*	50.00
060 DILATION OF URETHRA						15.00	12.00	5.00	15.00	10.00
061 PROSTATECTOMY						737.80*	792.00	684.50*	684.50*	570.40*
062 ELECTROSECTION-PROSTATE (TUR)	737.80*	737.80*	737.80*	737.80*	737.80*	641.70*	713.00*	650.00	738.60*	570.40*
063 HYSTERECTOMY						533.90*	700.00	575.00*	693.70*	684.50*
064 INITIAL COMPLETE EYE EXAM										
065 COMPREHENSIVE EYE EXAM										
066 EYE EXAM WITH TONOMETRY						15.00	11.30*	10.00*	10.00*	10.00*
067 EXTRACTION OF LENS	591.60*	600.00	691.60*	650.00	650.00	725.00	600.00	570.40*	570.40*	570.40*
068 CHEST X-RAY, SINGLE VIEW	14.30*	18.00	13.50	18.00	21.30*	24.70*	21.30*	15.00*	17.10*	25.00
069 CHEST X-RAY, TWO VIEWS	21.30*	20.00	14.00	25.70	24.30*	22.00	20.00	9.30	22.00	22.00
070 X-RAY SPINE						32.50	32.50	25.00*	32.50	28.50*
071 X-RAY HIP						20.00	20.00	17.90*	20.00	20.00
072 X-RAY UPPER GI TRACT	49.60*	53.00	53.00	53.00	42.80*	55.00	53.50*	35.60*	55.00	48.50*
073 X-RAY COLON						50.00	50.00	35.60*	49.90*	42.80*
074 RADIATION THERAPY-LOW VOLT	18.40*	18.40*	18.40*	18.40*	18.40*	13.10	13.10	13.10	13.10	13.10
075 RADIATION THERAPY-SUPER VOLT	24.70*	24.70*	24.70*	24.70*	24.70*	20.00*	20.00*	20.00*	20.00*	14.30*
076 RADIATION THERAPY-MEGAVOLT										
077 CAT SCAN - HEAD						262.50	262.50	262.50	262.50	262.50
078 CAT SCAN-HEAD, INTERPRET ONLY						67.50	67.50	67.50	55.80*	67.50
079 THREE CHEMISTRY TESTS										
080 TWELVE CHEMISTRY TESTS						18.00	15.00	29.00	18.00	18.00
081 CULTURE-OTHER THAN BLOOD						15.00	15.00	8.00	13.00	10.00
082 HEMOGLOBIN						3.00	3.00	3.00	3.50	4.00
083 AUTOMATED BLOOD COUNT						7.00	6.25	7.00	7.00	7.00
084 WHITE CELL COUNT						4.00	2.00	3.00	3.00	3.00
085 COMPLETE BLOOD COUNT (CBC)						10.00	9.50	8.50	10.00	11.00
086 CHOLESTEROL TEST						7.00	8.00	6.00	9.00	8.00
087 FLOCCULATION TEST						5.00	2.50	5.00	5.00	6.00
088 HEWATOCRIT						3.00	3.00	3.00	3.00	3.00
089 PLATELET COUNT (REES-ECKER)						6.00	6.00	7.00	7.00	6.00
090 POTASSIUM TEST						7.00	6.00	5.50	6.00	7.00
091 PROTHROMBIN						6.00	6.00	5.50	6.00	7.00
092 SEDIMENTATION RATE						6.00	5.00	6.00	6.00	6.00
093 BLOOD SUGAR						7.00	6.00	6.00	7.00	7.00
094 SUN-UREA, NITROGEN						7.00	8.00	6.00	7.00	8.00
095 URIC ACID						8.00	8.00	7.00	11.00	8.50
096 FECES-OCULT BLOOD						4.00	3.00	3.00	3.30	5.00
097 PAP TEST						10.00	8.00	10.00	10.00	13.00
098 ROUTINE URINALYSIS						5.50	5.00	4.00	5.50	5.00
099 CHEMICAL URINALYSIS						5.00	5.00	4.00	5.00	6.00
100 PATHOLOGY-THREE SPECIMENS						15.00	20.00	17.00	15.00	18.00

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

06 07 08 09 10

001 INITIAL BRIEF OFFICE VISIT	21.30*	28.50*	21.30*	25.00	23.00	21.30*	25.00*	25.70*	21.30*	001
002 INITIAL LIMITED OFFICE VISIT	35.00	21.90*	35.00*	35.00	21.30*	28.50*	28.50*	25.00	30.00*	002
003 INIT INTERMED OFFICE VISIT	3.00	2.90*	3.00	4.50	21.30*	28.50*	28.50*	25.00*	30.00*	003
004 INIT COMP OFFICE VISIT	8.60*	8.60*	8.60*	10.00*	40.00*	35.60*	42.80*	42.80*	40.00*	004
005 MINIMAL F/U OFFICE VISIT	14.30*	15.00	15.00	10.00*	5.00*	4.00	4.00	3.00	4.20*	005
006 BRIEF F/U OFFICE VISIT	14.30*	15.00	15.00	10.00*	10.00*	10.00*	10.00*	11.30*	11.30*	006
007 LIMITED F/U OFFICE VISIT	15.00	11.00	12.00	12.50	15.00	12.00	12.00	15.00*	12.00	007
008 INTERMED F/U OFFICE VISIT	20.00	20.00	20.00	20.00	20.00	20.00	20.00*	35.00	20.00	008
009 EXTENDED F/U OFFICE VISIT	22.10*	21.00*	28.00*	28.00*	45.00	21.30*	26.00	35.60*	35.60*	010
010 COMPLETE F/U OFFICE VISIT	14.30*	14.30*	17.10*	17.10*	16.50*	14.30*	10.00	14.30*	14.30*	011
011 BRIEF F/U HOME VISIT	25.00	15.00*	25.00	25.00*	18.00	18.00	15.10*	18.00	18.00	012
012 LIMITED F/U HOME VISIT	8.60*	8.60*	8.60	10.00*	27.60*	27.60*	20.50*	27.60*	27.60*	013
013 INTERMEDIATE F/U HOME VISIT	35.00	21.30*	28.50*	27.00	10.00*	10.00	10.00*	11.30	8.00	014
014 EXTENDED CARE FACILITY VISIT	50.00	50.00	50.00	50.00	35.60*	28.50*	21.30*	42.80*	28.50*	015
015 BRIEF F/U NURSING HOME VISIT	10.00*	8.60*	10.00*	10.00*	60.00	49.90*	45.00*	45.00	57.00*	016
016 INITIAL BRIEF HOSPITAL VISIT	17.10*	14.30*	14.30*	14.30*	14.30*	10.00	10.00*	11.30*	11.30*	017
017 INIT INTERMED HOSPITAL VISIT	20.00	20.00	20.00	20.00	15.00	12.00	13.00	20.00	15.00*	018
018 INITIAL COMP HOSPITAL VISIT	20.00	20.00	20.00	20.00	13.90*	9.00*	20.00	20.00	20.00	019
019 BRIEF F/U HOSPITAL VISIT	20.00	20.00	20.00	20.00	13.90*	9.00*	20.00	20.00	20.00	020
020 LIMITED F/U HOSPITAL VISIT	20.00	20.00	20.00	20.00	13.90*	9.00*	20.00	20.00	20.00	021
021 INTERMED F/U HOSPITAL VISIT	20.00	20.00	20.00	20.00	13.90*	9.00*	20.00	20.00	20.00	022
022 EXTENDED F/U HOSPITAL VISIT	20.00	20.00	20.00	20.00	25.80	19.40	19.00	22.20	23.40	023
023 BRIEF EMERGENCY ROOM VISIT	20.00	20.00	20.00	20.00	45.15	33.95	33.25	38.85	37.45	024
024 LIMITED EMERGENCY ROOM VISIT	20.00	20.00	20.00	20.00	12.20*	15.00	10.20*	12.00	11.70*	025
025 INTERMED EMERGENCY ROOM VISIT	20.00	20.00	20.00	20.00	25.00	25.00	25.00	25.00	25.00	026
026 LIMITED CONSULTATION	20.00	20.00	20.00	20.00	49.90*	35.60*	35.60*	35.60*	40.00	027
027 EXTENSIVE CONSULTATION	20.00	20.00	20.00	20.00	60.00	40.00*	35.60*	49.90*	35.60*	028
028 COMPREHENSIVE CONSULTATION	20.00	20.00	20.00	20.00	25.00	28.50*	24.30*	28.50*	35.60*	029
029 PSYCHOTHERAPY-ONE HOUR	20.00	20.00	20.00	20.00	20.00	30.00	20.00	24.20*	21.30*	030
030 PSYCHOTHERAPY-HALF HOUR	20.00	20.00	20.00	20.00	10.00	8.80*	8.80*	8.80*	8.80*	031
031 CHIROPRACTIC OFFICE VISIT	20.00	20.00	20.00	20.00	11.00	11.00	11.00	11.00	11.00	032
032 INITIAL PHYSIOTHERAPY	20.00	20.00	20.00	20.00	10.00*	10.00*	10.00*	11.30*	11.30*	033
033 F/U PODIATRIC OFFICE VISIT	20.00	20.00	20.00	20.00	16.00	20.00	20.00	20.00	20.00	034
034 ELECTROCARDIOGRAM (EKG)	20.00	20.00	20.00	20.00	6.60*	7.00	7.00	7.00	7.00	035
035 EKG-INTERPRET, REPORT ONLY	20.00	20.00	20.00	20.00	48.50	38.00	50.00	40.00	50.50	036
036 ARTERIAL BLOOD GAS STUDY	20.00	20.00	20.00	20.00	16.00	16.00	16.00	15.70*	16.00	037
037 ELECTROENCEPHALOGRAPH (EEG)	20.00	20.00	20.00	20.00	25.80	19.40	19.00	22.20	21.40	038
038 CHEMOTHERAPY	20.00	20.00	20.00	20.00	20.00	20.00	15.00*	15.00*	20.00	039
039 COLLECTION OF SPECIMENS	20.00	20.00	20.00	20.00	50.00	20.00*	35.60*	40.00*	35.60*	040
040 DEBRIDEMENT OF NAILS	20.00	20.00	20.00	20.00	24.00	24.00	24.00	24.00	24.00	041
041 SKIN BIOPSY	20.00	20.00	20.00	20.00	570.40*	600.00	641.70*	641.70*	667.40*	042
042 CHEMOCAUTERY	20.00	20.00	20.00	20.00	784.30*	570.40*	713.00*	620.00*	713.00*	043
043 RADICAL WASTECTOMY	20.00	20.00	20.00	20.00	40.00	40.00	30.00*	40.00	33.20*	044
044 OPEN REDUCTION OF FRACTURE	20.00	20.00	20.00	20.00	13.00	10.00	13.00*	12.00	10.00*	045
045 ARTHROCENTESIS-MAJOR JOINT	20.00	20.00	20.00	20.00	924.00*	1140.70*	1729.20*	1425.90*	1117.90*	046
046 ARTHROTOMY	20.00	20.00	20.00	20.00	15.00	15.00*	15.00*	12.00	11.30*	047
047 ARTHROPLASTY-REPAIR OF HIP	20.00	20.00	20.00	20.00	142.60*	178.20*	178.20*	173.20*	180.00	048
048 NEEDLE PUNCTURE OF BURSA	20.00	20.00	20.00	20.00	55.00	55.00	50.00*	35.60*	55.00	049
049 BRONCHOSCOPY	20.00	20.00	20.00	20.00						050
050 THORACENTESIS	20.00	20.00	20.00	20.00						

ILLINOIS

CONTINENTAL CASUALTY COMPANY

1979 PREVAILING CHARGE SUMMARY DATA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	06	07	08	09	10	06	07	08	09	10
1 CATHETERIZATION OF HEART						403.40*	403.40*	403.40*	360.00*	463.40*
2 INSERTION OF PACEMAKER						1150.00	1150.00	1150.00	855.60*	1150.00
053 PARTIAL COLECTOMY						713.00*	700.00	713.00*	800.00	834.20*
054 APPENDECTOMY						299.50*	356.50*	350.00*	400.00	400.00
055 SIGMOIDOSCOPY						35.00	35.00	35.00	30.00	25.00*
056 HEMORRHOIDECTOMY						285.20*	285.20*	320.80*	342.10	350.00
057 CHOLECYSTECTOMY						570.40*	534.75*	549.00*	600.00	598.90*
058 REPAIR HERNIA						350.00	306.50*	320.80*	356.50*	350.00
059 DIAGNOSTIC CYSTOURETHROSCOPY						49.90*	42.80*	49.90*	40.00	40.00*
060 DILATION OF URETHRA						15.00	14.30*	14.30*	7.10*	14.30*
061 PROSTATECTOMY						600.00*	713.00*	570.40*	641.70*	784.30*
062 ELECTROSECTION-PROSTATE (TUR)						713.00*	641.70*	534.75*	600.00	570.40*
063 HYSITERECTOMY						641.70*	534.75*	641.70*	606.00*	700.00
064 INITIAL COMPLETE EYE EXAM										
065 COMPREHENSIVE EYE EXAM						10.00	10.00	15.00	7.10*	11.30*
066 EYE EXAM WITH TONOMETRY						641.70*	600.00	713.00*	570.40*	570.40*
067 EXTRACTION OF LENS						18.60*	25.00	17.90*	21.30*	22.80*
068 CHEST X-RAY, SINGLE VIEW						21.30*	21.30*	22.00	21.30*	21.30*
069 CHEST X-RAY, TWO VIEWS						32.50	32.50	32.50	28.50*	32.50
070 X-RAY SPINE						20.00	20.00	20.00	20.00	20.00
071 X-RAY HIP						49.90*	49.90*	49.90*	51.30*	49.90*
072 X-RAY UPPER GI TRACT						49.90*	49.90*	49.90*	49.90*	49.90*
073 X-RAY COLON						13.10	13.10	13.10	13.10	13.10
074 RADIATION THERAPY-LOW VOLT						20.00	28.10*	20.00	20.00	20.00*
075 RADIATION THERAPY-SUPER VOLT						16.40*	10.00	21.00	18.40*	18.40*
076 RADIATION THERAPY-MEGAVOLT						24.70*	24.70*	26.00	24.70*	24.70*
077 CAT SCAN - HEAD						262.50	262.50	262.50	262.50	262.50
078 CAT SCAN-HEAD, INTERPRET ONLY						67.50	67.50	67.50	67.50	67.50
079 THREE CHEMISTRY TESTS						24.00	18.00	20.00	12.50	15.00
080 TWELVE CHEMISTRY TESTS						15.00	15.00	9.00	15.00	15.00
081 CULTURE-OTHER THAN BLOOD						3.00	3.00	3.00	5.00	3.00
082 HEMOGLOBIN						7.00	8.00	7.00	7.00	7.00
083 AUTOMATED BLOOD COUNT						5.00	4.00	4.00	5.00	3.00
084 WHITE CELL COUNT						8.00	10.00	8.00	8.00	8.00
085 COMPLETE BLOOD COUNT (CBC)						6.00	7.00	7.00	7.00	6.00
086 CHOLESTEROL TEST						5.00	5.00	5.00	5.00	5.00
087 FLOCCULATION TEST						3.00	3.00	3.00	3.00	3.00
088 HEMATOCRIT						5.00	6.00	8.00	3.00	6.00
089 PLATELET COUNT (REES-ECKER)						9.00	7.00	8.00	6.00	5.00
090 POTASSIUM TEST						6.00	6.00	5.00	5.00	7.00
091 PROTHROMBIN						5.00	6.00	4.00	4.00	6.00
092 SEDIMENTATION RATE						7.00	7.00	7.00	5.00	8.00
093 BLOOD SUGAR						7.00	7.00	7.00	5.00	6.00
094 SUN-UREA, NITROGEN						8.00	8.00	8.00	5.00	8.00
095 URIC ACID						3.00	4.00	3.00	3.00	4.00
096 FECES-OCCULT BLOOD						12.50	10.00	10.00	7.00	8.00
097 PAP TEST						5.50	5.50	6.00	4.75	5.50
098 ROUTINE URINALYSIS						5.00	5.00	5.00	3.50	5.00
099 CHEMICAL URINALYSIS						18.00	18.00	15.00	18.00	18.00
100 PATHOLOGY-THREE SPECIMENS										

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

	11	12	13	14	15	11	12	13	14	15
001 INITIAL BRIEF OFFICE VISIT	22.00	20.00	17.10*	21.30*	30.00	21.30*	21.30*	21.30*	31.00	28.50*
002 INITIAL LIMITED OFFICE VISIT						35.60*	35.60*	28.50*	47.75	35.60*
003 INIT INTERMED OFFICE VISIT						35.60*	35.60*	28.50*	47.75	35.60*
004 INIT COMP OFFICE VISIT	49.40*	44.40*	55.00	55.00	35.00*	35.60*	50.00*	40.00*	57.00*	75.00
005 MINIMAL F/U OFFICE VISIT	4.00	5.00	4.20*	2.90*	5.70*	2.90*	3.00	5.00	5.00*	5.70*
006 BRIEF F/U OFFICE VISIT	7.10*	8.60*	7.10*	8.60*	11.30*	10.00*	10.00*	8.60*	8.60*	14.30*
007 LIMITED F/U OFFICE VISIT	12.50	14.30*	14.00	14.30*	15.00	12.00	15.00*	13.00	12.00	15.00
008 INTERMED F/U OFFICE VISIT	12.00	10.50*	10.00	27.20*	20.00	15.00*	13.00	15.00	12.00	17.10*
009 EXTENDED F/U OFFICE VISIT	20.00*	20.00*	20.00*	15.00	20.00*	20.00*	14.30*	20.00	20.00	15.00
010 COMPLETE F/U OFFICE VISIT	28.00*	28.00*	22.10*	30.00	25.00	28.00*	28.00*	45.60*	45.60*	50.00
011 BRIEF F/U HOME VISIT	14.30*	14.30*	14.30*	14.30*	20.00	14.30*	15.00	14.30*	14.30*	21.30*
012 LIMITED F/U HOME VISIT						18.00	18.00	17.10*	18.00	19.00
013 INTERMEDIATE F/U HOME VISIT	25.00	25.00*	25.00	20.00	25.00	29.10*	27.60*	27.60*	27.60*	25.00
014 EXTENDED CARE FACILITY VISIT						10.00*	10.00*	8.60*	8.60*	14.30*
015 BRIEF F/U NURSING HOME VISIT	7.10*	8.60	7.10*	8.60*	11.30*	10.00*	10.00*	8.60*	8.60*	14.30*
016 INITIAL BRIEF HOSPITAL VISIT	21.30*	21.30*	35.00	28.50*	35.60*	28.50*	28.50*	28.50*	28.50*	42.80*
017 INIT INTERMED HOSPITAL VISIT						64.10*	40.00	49.90*	45.60*	60.00
018 INITIAL COMP HOSPITAL VISIT	44.90*	45.00*	50.00*	50.00	50.00	60.00	45.00*	57.00*	57.00*	71.30*
019 BRIEF F/U HOSPITAL VISIT	10.00*	8.60*	12.00	8.60*	15.00*	11.30*	11.30*	12.00	10.00*	14.30*
020 LIMITED F/U HOSPITAL VISIT	14.30*	14.30*	17.50	20.00	21.30*	30.00	24.30*	21.30*	25.00	25.00
021 INTERMED F/U HOSPITAL VISIT						20.00	15.70*	20.00	20.00	20.00*
022 EXTENDED F/U HOSPITAL VISIT						20.00	15.70*	20.00	20.00	20.00*
023 BRIEF EMERGENCY ROOM VISIT						21.20	21.40	21.00	18.80	27.20
024 LIMITED EMERGENCY ROOM VISIT						37.10	37.45	36.75	32.90	47.60
025 INTERMED EMERGENCY ROOM VISIT	17.00*	20.00	20.00*	20.00	14.30*	14.00	14.40*	12.80*	13.80*	12.40*
026 LIMITED CONSULTATION						25.00	25.00	25.00	25.00	25.00
027 EXTENSIVE CONSULTATION						35.00	35.60*	35.60*	45.00	49.90*
028 COMPREHENSIVE CONSULTATION						35.60*	42.80*	42.80*	60.00	71.30*
029 PSYCHOTHERAPY-ONE HOUR						28.50*	21.30*	35.60*	44.10*	35.60*
030 PSYCHOTHERAPY-HALF HOUR						18.00*	16.50*	27.50*	30.00	25.00*
031 CHIROPRACTIC OFFICE VISIT	13.10*	13.10*	13.10*	17.60*	21.50*	10.00	8.80*	8.80*	8.00*	12.00
032 INITIAL PHYSIOTHERAPY						11.00	11.00	11.00	11.00	11.00
033 F/U PODIATRIC OFFICE VISIT						10.00*	10.00*	8.60*	8.60*	14.30*
034 ELECTROCARDIOGRAM (EKG)	15.00	20.00	18.00	21.30*	20.00	17.00	21.30*	20.00	20.00	20.00
035 EKG-INTERPRET. REPORT ONLY	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	6.25	7.00
036 ARTERIAL BLOOD GAS STUDY						47.00	47.00	44.00	47.50	55.00
037 ELECTROENCEPHALOGRAPH (EEG)						16.00	16.00	16.00	16.00	16.00
038 CHEMOTHERAPY						21.20	21.40	21.00	18.00	27.20
039 COLLECTION OF SPECIMENS						16.60*	20.00	18.10*	20.00	20.00
040 DEBRIDEMENT OF NAILS						25.00*	50.00	35.60*	42.80*	37.50*
041 SKIN BIOPSY						24.00	24.00	24.00*	24.00	24.00
042 CHEMOCAUTERY						513.40*	713.00*	641.70*	593.90*	855.60*
043 RADICAL MASTECTOMY						570.40*	900.00	570.40*	684.50*	855.60*
044 OPEN REDUCTION OF FRACTURE						25.90*	40.00	40.00	40.00	40.00
045 ARTHROCENTESIS-MAJOR JOINT						14.30*	10.00	13.00	13.00	10.00
046 ARTHROTOMY						1729.20*	1212.10*	1404.90*	1729.20*	1425.90*
047 ARTHROPLASTY-REPAIR OF HIP	8.00	10.00	10.00	9.00	16.00	15.00*	10.00	15.00	15.00*	15.00
048 NEEDLE PUNCTURE OF BURSA						107.00*	150.00*	142.60*	128.30*	199.50*
049 BRONCHOSCOPY						50.00*	49.90*	50.00*	49.90*	71.30*
050 THORACENTESIS										

1979 PREVAILING CHARGE SUMMARY DATA CONTINENTAL CASUALTY COMPANY

ILLINOIS

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	11	12	13	14	15	11	12	13	14	15
051 CATHETERIZATION OF HEART						403.40*	403.40	403.40*	403.40*	520.00
052 INSERTION OF PACEMAKER						1150.00	1150.00	1150.00	1150.00*	1200.00
053 PARTIAL COLECTOMY						570.40*	606.00*	855.60*	641.70*	960.00
054 APPENDECTOMY						356.50*	356.50*	400.00	285.20*	400.00
055 SIGMOIDOSCOPY	25.00	21.30*	28.50*	21.30*	35.00	35.60*	25.00*	35.00	28.50*	35.60*
056 HEMORRHOIDECTOMY						285.00*	249.60*	285.00*	285.00*	350.00
057 CHOLECYSTECTOMY						570.40*	570.40*	570.40*	556.10*	713.00*
058 REPAIR HERNIA						320.80*	342.10*	356.50*	285.20*	427.80*
059 DIAGNOSTIC CYSTOURETHROSCOPY	50.00	50.00	50.00	41.90*	58.90*	49.90*	49.90*	50.00	42.80*	60.00
060 DILATION OF URETHRA						6.40*	20.00	14.30*	8.60*	14.30*
061 PROSTATECTOMY						713.00*	713.00*	600.00*	720.10*	798.60*
062 ELECTROSECTION-PROSTATE (TUR)	612.70*	737.80*	550.00*	737.80*	941.90*	641.70*	700.00	750.00	598.90*	713.00*
063 HYSTERECTOMY						570.40*	641.70*	570.40*	684.50*	700.00
064 INITIAL COMPLETE EYE EXAM										
065 COMPREHENSIVE EYE EXAM						9.20*	10.00*	15.00	10.00*	14.30*
066 EYE EXAM WITH TOMOMETRY						675.00	656.00*	641.70*	570.40*	784.30*
067 EXTRACTION OF LENS	675.00	675.00	691.60*	691.60*	691.60*	17.10*	21.30*	25.00	18.60*	21.30*
068 CHEST X-RAY, SINGLE VIEW	14.30*	16.00	14.30*	20.00	21.30*	22.00	21.30*	22.00	22.00	22.00
069 CHEST X-RAY, TWO VIEWS	14.00	20.00	15.00*	20.00	22.80*	28.50*	30.00	32.50	32.50	35.00
070 X-RAY SPINE						20.00	20.00	20.00	20.00	20.00
071 X-RAY HIP						40.00*	42.80*	42.80*	55.00	42.00
072 X-RAY UPPER GI TRACT	43.90*	53.00	50.70*	49.90*	42.80*	50.00	42.80*	42.80*	50.00	42.80*
073 X-RAY COLON						13.10	13.10	13.10	13.10	13.10
074 RADIATION THERAPY-LOW VOLT	19.40*	18.40*	18.40*	18.40*	18.40*	20.00	10.00*	20.00	29.80	20.00*
075 RADIATION THERAPY-SUPER VOLT	26.00	24.70*	24.70*	26.00	22.00					
076 RADIATION THERAPY-MEGAVOLT										
077 CAT SCAN - HEAD						262.50	262.50	262.50	262.50	262.50
078 CAT SCAN-HEAD, INTERPRET ONLY						67.50	67.50	67.50	67.50	48.20*
079 THREE CHEMISTRY TESTS						18.00	20.00	20.00	18.00	19.00
080 TWELVE CHEMISTRY TESTS						15.00	12.00	8.25	15.00	12.00
081 CULTURE-OTHER THAN BLOOD						3.00	4.00	2.50	3.00	4.50
082 HEMOGLOBIN						7.00	7.00	7.00	7.75	7.00
083 AUTOMATED BLOOD COUNT						4.00	4.00	2.00	4.00	4.50
084 WHITE CELL COUNT						6.25	10.00	8.25	10.00	10.00
085 COMPLETE BLOOD COUNT (CBC)						9.00	7.00	7.00	7.00	8.00
086 CHOLESTEROL TEST						5.00	6.00	5.00	5.00	5.50
087 FLOCCULATION TEST						3.00	3.00	3.00	3.00	4.50
088 HEVATOPIIT						7.00	5.00	6.00	6.00	6.00
089 PLATELET COUNT (REES-ECKER)						6.00	5.00	5.75	7.00	8.00
090 POTASSIUM TEST						6.25	4.50	5.00	6.75	6.00
091 PROTHROMBIN						6.00	5.00	5.00	6.00	5.00
092 SEDIMENTATION RATE						6.00	7.00	6.00	7.00	8.00
093 BLOOD SUGAR						6.00	6.00	7.00	7.00	8.00
094 BUN-UREA, NITROGEN						8.00	6.00	7.00	8.00	9.00
095 URIC ACID						4.00	4.00	3.00	4.00	5.00
096 FECS-OCULT BLOOD						10.00	7.00	10.00	10.00	10.00
097 PAP TEST						4.00	9.00	4.00	5.50	8.00
098 ROUTINE URINALYSIS						4.00	4.00	4.00	5.00	5.00
099 CHEMICAL URINALYSIS						18.00	15.00	20.00	18.00	20.00
100 PATHOLOGY-THREE SPECIMENS										

INDIANA

A map of the state of Georgia, divided into its 159 counties. Each county is labeled with its name and a number (01 or 02) indicating its position in the alphabetical sequence. The map shows the geographical boundaries of each county and their relative positions within the state.

Three Localities:
01 - Metropolitan
02 - Urban
03 - Rural
(For more locality information
see Appendix A)

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

REG 01

REG 02

REG 03

REG 01

REG 02

REG 03

001 INITIAL BRIEF OFFICE VISIT	15.70*	15.00*	14.30*	34.00	17.10*	15.00
002 INITIAL LIMITED OFFICE VISIT				34.00	17.10*	15.00
003 INIT INTERMED OFFICE VISIT				49.50*	42.80*	42.80*
004 INIT COMP OFFICE VISIT	30.00	25.00	25.00	49.50*	42.80*	42.80*
005 MINIMAL F/U OFFICE VISIT	11.40*	10.00	8.60*	14.30*	11.40*	10.00*
006 BRIEF F/U OFFICE VISIT	11.40*	10.00	8.60*	14.30*	11.40*	10.00*
007 LIMITED F/U OFFICE VISIT	11.40*	10.00	8.60*	14.30*	11.40*	10.00*
008 INTERMED F/U OFFICE VISIT	15.70*	14.30*	12.80*	17.10*	15.70*	14.30*
009 EXTENDED F/U OFFICE VISIT	15.70*	15.00*	14.30*	34.00	17.10*	15.00
010 COMPLETE F/U OFFICE VISIT	30.00	25.00	25.00	49.50*	42.80*	42.80*
011 BRIEF F/U HOME VISIT	17.10*	15.00	14.30*	15.00*	17.10*	10.00*
012 LIMITED F/U HOME VISIT				18.50*	18.50*	20.00*
013 INTERMEDIATE F/U HOME VISIT	21.40*	17.10*	17.10*	18.50*	18.50*	20.00*
014 EXTENDED CARE FACILITY VISIT				21.40*	17.10*	14.30*
015 BRIEF F/U NURSING HOME VISIT	11.40*	10.00	8.60*	14.30*	11.40*	10.00*
016 INITIAL BRIEF HOSPITAL VISIT	35.70*	35.00	28.50*	57.00*	49.90*	35.70*
017 INIT INTERMED HOSPITAL VISIT				57.00*	49.90*	35.70*
018 INITIAL COMP HOSPITAL VISIT	35.70*	35.00	28.50*	57.00*	49.90*	35.70*
019 BRIEF F/U HOSPITAL VISIT	11.40*	10.00*	8.60*	14.30*	11.40*	10.00*
020 LIMITED F/U HOSPITAL VISIT	11.40*	10.00*	8.60*	14.30*	11.40*	10.00*
021 INTERMED F/U HOSPITAL VISIT	11.40*	10.00*	8.60*	14.30*	11.40*	10.00*
022 EXTENDED F/U HOSPITAL VISIT				14.30*	11.40*	10.00*
023 BRIEF EMERGENCY ROOM VISIT				14.30*	11.40*	10.00*
024 LIMITED EMERGENCY ROOM VISIT				47.50*	41.00	45.20*
025 INTERMED EMERGENCY ROOM VISIT				51.50	41.00	45.20*
026 LIMITED CONSULTATION						
027 EXTENSIVE CONSULTATION				64.00	49.90*	49.90*
028 COMPREHENSIVE CONSULTATION				50.00	47.20*	42.50*
029 PSYCHOTHERAPY-ONE HOUR				35.70*	35.70*	35.70*
030 PSYCHOTHERAPY-HALF HOUR				25.70*	25.00	25.70*
031 CHIROPRACTIC OFFICE VISIT				10.00	10.00	9.00
032 INITIAL PHYSIOTHERAPY				21.40*	20.00	16.00
033 F/U PODIATRIC OFFICE VISIT				11.40*	11.40	12.80
034 ELECTROCARDIOGRAM (EKG)	20.00	20.00	20.00	20.00	20.00	20.00
035 EKG-INTERPRET, REPORT ONLY	7.00	5.00	21.00	7.00	5.00	21.00
036 ARTERIAL BLOOD GAS STUDY						
037 ELECTROENCEPHALOGRAM (EEG)				40.00	49.90	45.00
038 CHEMOTHERAPY						
039 COLLECTION OF SPECIMENS				7.00	7.00	3.00
040 DEBRIDEMENT OF NAILS				10.00	12.00	10.00
041 SKIN BIOPSY				15.00	15.00	15.00
042 CHEMOCAUTERY				47.50*	19.00*	32.50*
043 RADICAL MASTECTOMY				600.00	570.40*	641.70*
044 OPEN REDUCTION OF FRACTURE				713.00*	641.70*	713.00*
045 ARTHROCENTESIS-MAJOR JOINT						
046 ARTHROTOMY						
047 ARTHROPLASTY-REPAIR OF HIP	28.50*	15.00	20.00	25.00	21.40*	25.00
048 NEEDLE PUNCTURE OF BURSA				855.60*	750.00	784.30*
049 BRONCHOSCOPY				25.00	25.00	25.00
050 THORACENTESIS				142.60*	125.00*	142.60*
				35.70*	35.00	35.70*

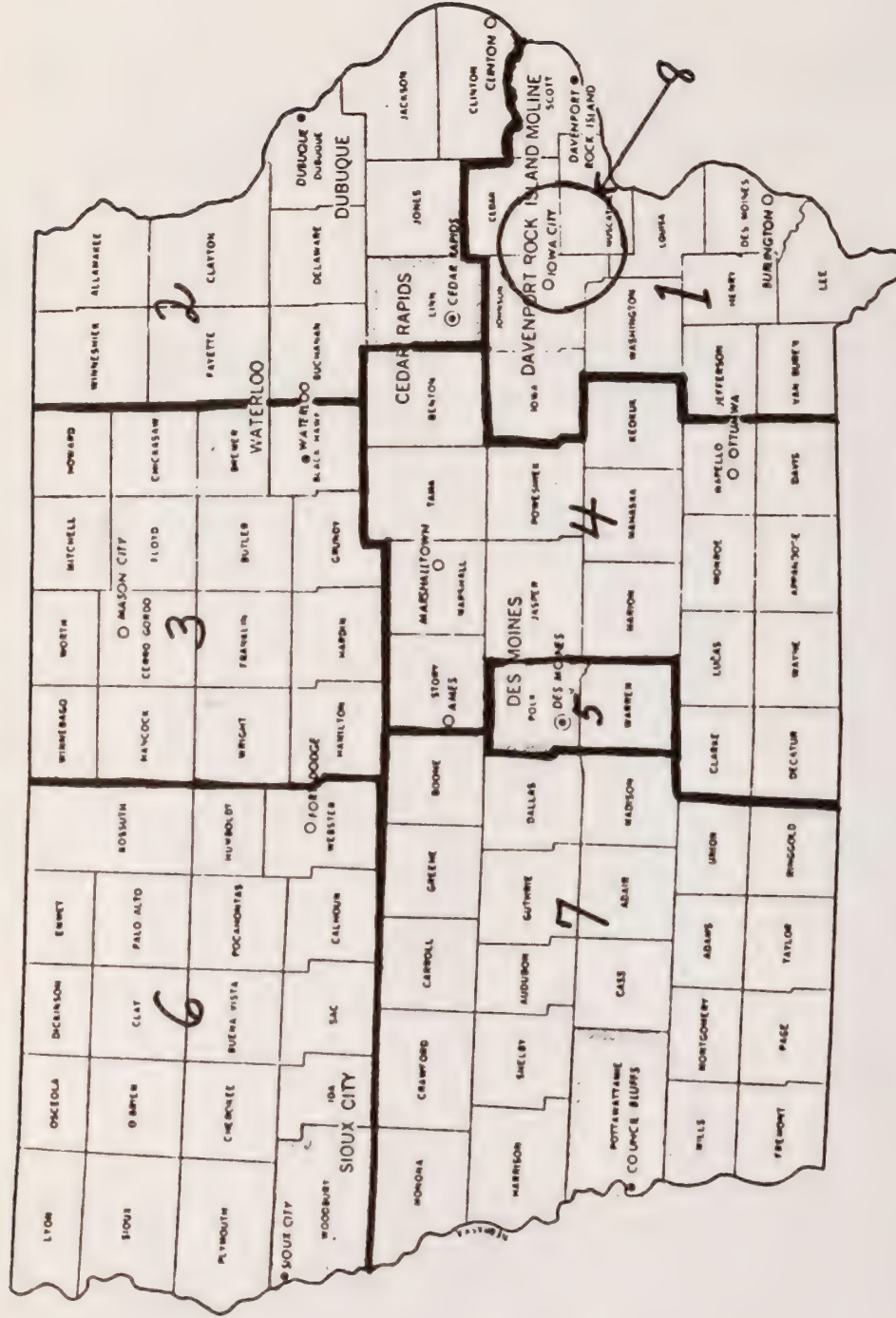
INDIANA

1979 PREVAILING CHARGE SUMMARY DATA MUTUAL MEDICAL INSURANCE

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	REG 01	REG 02	REG 03	REG 01	REG 02	REG 03
051 CATHETERIZATION OF HEART				442.10*	419.20*	462.00*
052 INSERTION OF PACEMAKER				656.00*	713.00*	656.00*
053 PARTIAL COLECTOMY				713.00*	641.70*	570.40*
054 APPENDICECTOMY				356.50*	285.20*	249.60*
055 SIGMOIDOSCOPY			28.50*	35.00	35.00	28.50*
056 HEMORRHOIDECTOMY	28.50*	28.50*		350.00	249.60*	275.00
057 CHOLECYSTECTOMY				550.00	499.10*	463.50*
058 REPAIR HERNIA				356.50*	285.20*	285.20*
059 DIAGNOSTIC CYSTOURETHROSCOPY	49.90*	45.00	49.90*	49.90*	45.00	49.90*
060 DILATION OF URETHRA				14.30*	10.00*	15.00
061 PROSTATECTOMY				713.00*	570.40*	684.50*
062 ELECTROSECTION-PROSTATE (TURP)	684.50*	680.00	684.50*	684.50*	577.50*	684.50*
063 HYSTERECTOMY				641.70*	570.40*	641.70*
064 INITIAL COMPLETE EYE EXAM				24.00	21.40*	20.00
065 COMPREHENSIVE EYE EXAM						
066 EYE EXAM WITH TONOMETRY						
067 EXTRACTION OF LENS	700.00	570.40*	606.10*	700.00	570.40*	606.10*
068 CHEST X-RAY, SINGLE VIEW	21.40*	14.30*	14.30*	20.00	22.00	17.50
069 CHEST X-RAY, TWO VIEWS	21.40*	21.40*	20.00	21.40*	21.40*	21.00
070 X-RAY SPINE				31.40*	28.50*	29.90*
071 X-RAY HIP				20.00	20.00	17.50
072 X-RAY UPPER GI TRACT	42.80*	42.80*	35.70*	42.80*	42.80*	35.70*
073 X-RAY COLON				40.50	42.80*	35.70*
074 RADIATION THERAPY-LOW VOLT	16.20	20.00	15.00*	15.00	15.00	15.00
075 RADIATION THERAPY-SUPER VOLT	18.00	17.00	15.00*	18.00	17.00	18.00
076 RADIATION THERAPY-MEGAVOLT						
077 CAT SCAN - HEAD				285.00	272.40	256.70*
078 CAT SCAN-HEAD, INTERPRET ONLY				75.00	140.00	285.00
079 THREE CHEMISTRY TESTS				18.00	20.00	25.00
080 TWELVE CHEMISTRY TESTS				10.00	12.00	12.00
081 CULTURE-OTHER THAN BLOOD				4.00	3.00	3.00
082 HEMOGLOBIN						
083 AUTOMATED BLOOD COUNT				3.00	3.00	4.00
084 WHITE CELL COUNT				8.00	8.00	8.00
085 COMPLETE BLOOD COUNT (CBC)				7.00	6.00	6.00
086 CHOLESTEROL TEST				5.00	3.00	6.00
087 FLOCCULATION TEST				3.00	3.00	3.00
088 HEMATOCRIT				7.00	6.50	3.00
089 PLATELET COUNT (REES-ECKER)				7.00	6.00	6.00
090 POTASSIUM TEST				6.00	5.00	5.00
091 PROTHROMBIN				5.00	5.00	5.00
092 SEDIMENTATION RATE				6.00	5.00	6.00
093 BLOOD SUGAR				7.00	6.00	6.00
094 BUN-UREA, NITROGEN				7.00	6.00	7.00
095 URIC ACID				3.00	3.00	3.00
096 FECES-OCULT BLOOD				10.00	3.00	3.00
097 PAP TEST				4.40	6.00	10.00
098 ROUTINE URINALYSIS					4.50	4.00
099 CHEMICAL URINALYSIS						
100 PATHOLOGY-THREE SPECIMENS				20.00	17.00	18.00

IOWA

IOWA



Right Localities:

- 01 - Lee, Van Buren, Des Moines, Henry, Jefferson, Louisa, Washington, Muscatine, Johnson (excluding Iowa City), Iowa, Edar & Scott Counties
- 02 - Clinton, Jackson, Jones, Linn, Buchanan, Delawar, Dubuque, Clayton, Fayette, Allamakee & Winneshiek Counties
- 03 - Black Hawk, Grundy, Hardin, Hamilton, Wright, Cerro Gordo, Floyd, Chickasaw, Howard, Mitchell, Worth, Winnebago, Hancock, Franklin, Butler & Brenner
- 04 - Denton, Tanna, Marshall, Story, Casper, Paweshiek, Keokuk, Mahaska, Marion, Wapello, Monroe, Lucas, Clarke, Davis Appanoose, Decatur Counties

05 - Polk & Warren Counties

06 - Kossuth, Humboldt, Webster, Calhoun, Pocahontas, Palo Alto, Emmet, Dickinson, Bueno Vista, Clay, Sac, Ida, Woodbury, Cherokee, Plymouth, O'Brien, Souix, Lyon & Osceola Counties

07 - Monora, Crawford, Carroll, Greene, Boone, Harrison, Shelby, Audubon, Guthrie, Dallas, Madison, Adair, Cass, Pottawattamie, Mills, Montgomery, Adams, Union, Fremont, Page, Taylor, & Ringold Counties

08 - Iowa City (Includes the University of Iowa hospital. The city limits are the boundaries of the locality.)

1979 PREVAILING CHARGE SUMMARY DATA

IOWA

B/S OF IOWA

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	01	02	03	04	05	01	02	03	04	05
001 INITIAL BRIEF OFFICE VISIT	15.00	21.40*	21.40*	21.40*	21.00	10.00	9.00*	10.70*	10.00	10.70*
002 INITIAL LIMITED OFFICE VISIT						28.50*	45.00	28.50*	35.70*	35.00
003 INIT INTERMED OFFICE VISIT	40.00	28.50*	25.00*	28.50*	28.50*	40.00*	40.00	28.50*	50.00	39.90*
004 INIT COMP OFFICE VISIT	3.00	4.30*	5.00*	3.00	3.00	3.00	5.00	5.00	5.70*	5.00
005 MINIMAL F/U OFFICE VISIT	8.60*	8.60*	8.60*	7.10*	10.00	10.00	9.00*	10.70*	10.00	10.70*
006 BRIEF F/U OFFICE VISIT	15.00	14.30*	14.30*	14.30*	17.10*	28.50*	11.40*	14.30*	20.00	17.10*
007 LIMITED F/U OFFICE VISIT	11.40	10.00	11.00	11.40*	7.00	20.00	12.00	14.30*	14.30*	15.00*
008 INTERMED F/U OFFICE VISIT	15.00*	21.40*	21.40*	21.40*	21.00	28.50*	45.00	28.50*	35.70*	35.00
009 EXTENDED F/U OFFICE VISIT	40.00	28.50*	25.00*	28.40*	28.50*	40.00*	40.00	28.50*	50.00	39.90*
010 COMPLETE F/U OFFICE VISIT	14.30*	14.30*	12.80*	13.00	14.30*	15.00*	14.30*	12.80*	14.30*	15.00*
011 BRIEF F/U HOME VISIT						21.00	17.80*	17.10*	14.30*	21.00
012 LIMITED F/U HOME VISIT						10.00	10.00	10.00	10.00	10.00
013 INTERMEDIATE F/U HOME VISIT						10.00	9.00	10.70*	10.00	10.70*
014 EXTENDED CARE FACILITY VISIT	10.00	8.60*	8.60*	7.10*	10.00*	40.00*	45.00*	42.80*	35.70*	49.90
015 BRIEF F/U NURSING HOME VISIT	21.40	28.50*	28.50*	27.10*	35.00*					
016 INITIAL BRIEF HOSPITAL VISIT						40.00	45.00	42.80*	35.70*	49.90*
017 INIT INTERMED HOSPITAL VISIT						10.00*	11.40*	11.40*	11.40*	10.00
018 INITIAL COMP HOSPITAL VISIT	21.40*	28.50*	28.50*	27.10*	35.00	15.00*	12.80*	14.30*	14.30*	22.80*
019 BRIEF F/U HOSPITAL VISIT	8.60*	8.60*	8.60*	10.00*	10.00*					
020 LIMITED F/U HOSPITAL VISIT	20.00	10.00*	12.00*	14.30*	15.00					
021 INTERMED F/U HOSPITAL VISIT						35.70*	42.80*	49.90*	35.70*	50.00
022 EXTENDED F/U HOSPITAL VISIT						40.00	50.00	60.00	60.00*	71.30*
023 BRIEF EMERGENCY ROOM VISIT						57.00*	50.00	57.00*	42.80*	71.30*
024 LIMITED EMERGENCY ROOM VISIT						12.50	11.00	12.50	10.00	17.50
025 INTERMED EMERGENCY ROOM VISIT						12.50	11.00	12.50	10.00	17.50
026 LIMITED CONSULTATION	30.00	25.00	35.70*	25.00	35.70*	9.00	9.00	8.00	9.00	10.00
027 EXTENSIVE CONSULTATION						9.80*	9.80*	9.80	9.80*	10.00
028 COMPREHENSIVE CONSULTATION										
029 PSYCHOTHERAPY-ONE HOUR										
030 PSYCHOTHERAPY-HALF HOUR										
031 CHIROPRACTIC OFFICE VISIT										
032 INITIAL PHYSIOTHERAPY										
033 F/U PODIATRIC OFFICE VISIT										
034 ELECTROCARDIOGRAM (EKG)	15.00	20.00	20.00	25.00	22.00	18.00	25.00	20.00	25.00	22.00
035 EKG-INTERPRET-REPORT ONLY	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00
036 ARTERIAL BLOOD GAS STUDY						23.00	23.00	23.00	23.00	23.00
037 ELECTROENCEPHALOGRAM (EEG)						80.00	80.00	80.00	80.00	80.00
038 CHEMOTHERAPY						5.00	5.00	5.00	5.00	5.00
039 COLLECTION OF SPECIMENS						3.00	3.00	3.00	3.00	3.00
040 DEBRIDEMENT OF NAILS						11.00	12.00	12.00	12.00	14.00*
041 SKIN BIOPSY						25.00	21.40*	25.70	25.00	21.40*
042 CHEMOCAUTERY						35.00*	45.00	45.00	45.00	45.00
043 RADICAL MASTECTOMY						492.10*	534.75*	570.40*	570.40*	570.40*
044 OPEN REDUCTION OF FRACTURE						492.00*	470.60*	434.90*	463.50*	413.50*
045 ARTHROCENTESIS-MAJOR JOINT						21.40*	28.50*	25.00*	21.40*	21.40*
046 ARTHROTOMY						21.40*	28.50*	25.00*	21.40*	21.40*
047 ARTHROPLASTY-REPAIR OF HIP						713.00*	713.00*	731.00*	713.00*	713.00*
048 NEEDLE PUNCTURE OF BURSA						17.10*	17.10*	17.10*	15.00*	17.10*
049 BRONCHOSCOPY						142.60*	142.60*	125.00*	110.00*	175.00
050 THORACENTESIS	20.00	15.70*	18.00	20.00	20.00	49.90*	60.00	35.70*	25.00*	35.70*

1979 PREVAILING CHARGE SUMMARY DATA B/S OF IOWA

IOWA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	04	05	01	02	03	04	05
051 CATHETERIZATION OF HEART						427.80	427.80*	427.80*	427.80*	427.80*
052 INSERTION OF PACEMAKER						825.00	713.00*	427.80*	420.00*	627.40*
053 PARTIAL COLECTOMY						713.00*	700.00	675.00*	550.00*	784.30*
054 APPENDICECTOMY						293.20*	320.90	285.20*	285.20*	298.00*
055 SIGMOIDECTOMY						33.00	28.50*	21.40*	21.40*	35.70*
056 HEMORRHOIDECTOMY					25.00	225.00	249.60*	285.20*	225.00	320.90*
057 CHOLECYSTECTOMY						499.10*	499.10*	427.80*	427.80*	499.10*
058 REPAIR HERNIA						285.20*	310.00	285.20*	280.00	285.20*
059 DIAGNOSTIC CYSTOURETHROSCOPY						42.30*	42.80*	60.00	35.70*	50.00
060 DILATION OF URETHRA					50.00	15.00*	17.00	14.30*	15.00*	14.30*
061 PROSTATECTOMY						570.40*	570.40*	570.40*	570.40*	570.40*
062 ELECTROSECTION-PROSTATE (TURP)					570.40*	570.40*	570.40*	641.70*	570.40*	570.40*
063 HYPOPLASTIC						534.75*	556.10*	499.10*	570.40*	570.40*
064 INITIAL COMPLETE EYE EXAM						22.80*	20.00	21.00	14.30*	22.80*
065 COMPREHENSIVE EYE EXAM										
066 EYE EXAM WITH TONOMETRY						606.10*	625.00	570.40	570.40*	570.40*
067 EXTRACTION OF LENS					570.40*	17.10*	21.40*	12.00	21.40*	21.40*
068 CHEST X-RAY, SINGLE VIEW					20.00	25.00	21.40*	15.00*	21.40*	21.40*
069 CHEST X-RAY, TWO VIEWS					21.40*	30.00	21.40*	21.40*	28.50*	21.40*
070 X-RAY SPINE						21.40	21.40*	17.50*	21.40*	17.50*
071 X-RAY HIP					35.00	42.80	44.50	35.00*	40.00	35.70*
072 X-RAY UPPER GI TRACT						35.70	45.50	35.00*	40.00	35.70*
073 X-RAY COLON										
074 RADIATION THERAPY-LOW VOLT						150.00	150.00	150.00	150.00	150.00
075 RADIATION THERAPY-SUPER VOLT						35.00	35.00	35.00	35.00	35.00
076 RADIATION THERAPY-MEGAVOLT						18.00	15.00	15.00	15.00	17.00
077 CAT SCAN - HEAD						13.00	19.00	16.00	10.00	11.00
078 CAT SCAN-HEAD, INTERPRET ONLY						12.00	10.00	8.00	10.00	10.00
079 THREE CHEMISTRY TESTS										
080 TWELVE CHEMISTRY TESTS										
081 CULTURE-OTHER THAN BLOOD										
082 HEMOGLOBIN										
083 AUTOMATED BLOOD COUNT										
084 WHITE CELL COUNT						3.00	3.00	3.00	3.00	3.00
085 COMPLETE BLOOD COUNT (CBC)						9.00	10.00	9.00	11.00	9.00
086 CHOLESTEROL TEST						6.10	6.00	6.00	7.00	6.00
087 FLOCCULATION TEST						6.00	6.00	6.00	6.00	6.00
088 HEMATOOCRIT						3.00	3.00	3.00	3.00	3.00
089 PLATELET COUNT (REES-ECKER)						4.00	5.00	6.00	5.00	5.00
090 POTASSIUM TEST						6.00	7.00	7.00	8.00	6.00
091 PROTHROMBIN						5.00	5.00	5.00	5.00	5.00
092 SEDIMENTATION RATE						3.00	5.00	5.00	4.00	3.00
093 BLOOD SUGAR						6.00	6.00	6.00	6.00	6.00
094 SUN-UREA-NITROGEN						5.00	6.00	6.00	7.50	6.00
095 URIC ACID						6.00	6.00	8.00	6.50	7.00
096 FECES-OCCULT BLOOD						2.50	3.00	2.00	3.00	3.00
097 PAP TEST						7.50	7.10	8.00	8.00	6.50
098 ROUTINE URINALYSIS						4.00	4.00	4.00	4.00	5.00
099 CHEMICAL URINALYSIS										
100 PATHOLOGY-THREE SPECIMENS						18.50	20.00	24.00	17.50	30.00

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	06	07	08	06	07	08
001 INITIAL BRIEF OFFICE VISIT	21.40*	18.50*		11.40*	12.10*	21.40*
002 INITIAL LIMITED OFFICE VISIT			25.00	30.00	45.00	40.00
003 INIT INTERMED OFFICE VISIT				14.30*	20.00	14.30*
004 INIT COMP OFFICE VISIT	35.00	21.40*	28.50*	45.00	49.90*	90.00
005 MINIMAL F/U OFFICE VISIT	3.00	3.00	3.00	3.00	5.00	5.00
006 BRIEF F/U OFFICE VISIT	8.60*	8.60*	10.00	11.40*	12.10*	15.00*
007 LIMITED F/U OFFICE VISIT	12.00	15.00	14.30*	14.30*	14.30*	14.30*
008 EXTENDED F/U OFFICE VISIT	11.40*	11.40*	11.00	14.30*	20.00	14.30*
009 INTERMED F/U OFFICE VISIT	21.40*	18.50*	25.00	30.00	45.00	40.00
010 COMPLETE F/U OFFICE VISIT	35.00	21.40*	28.50*	45.00	49.90*	90.00
011 BRIEF F/U HOME VISIT	11.40*	14.30*	14.30*	11.40	13.00	14.30*
012 LIMITED F/U HOME VISIT				14.30	21.00	17.80*
013 INTERMEDIATE F/U HOME VISIT						
014 EXTENDED CARE FACILITY VISIT				10.00	10.00	10.00
015 BRIEF F/U NURSING HOME VISIT	8.60*	8.60*	10.00	10.00	9.00	15.00
016 INITIAL BRIEF HOSPITAL VISIT	28.50	28.50*	42.00*	49.90*	49.90*	70.00*
017 INIT INTERMED HOSPITAL VISIT						
018 INITIAL COMP HOSPITAL VISIT	28.50*	28.50*	42.00	49.90*	49.90*	70.00
019 BRIEF F/U HOSPITAL VISIT	10.00	10.00*	12.80*	10.00*	14.30*	12.80*
020 LIMITED F/U HOSPITAL VISIT	21.40*	15.00	17.10*	15.00*	25.00	15.00*
021 INTERMED F/U HOSPITAL VISIT						
022 EXTENDED F/U HOSPITAL VISIT						
023 BRIEF EMERGENCY ROOM VISIT						
024 LIMITED EMERGENCY ROOM VISIT						
025 INTERMED EMERGENCY ROOM VISIT						
026 LIMITED CONSULTATION	30.00	35.70*	35.00	49.90*	35.70*	40.00
027 EXTENSIVE CONSULTATION				50.00	60.00	40.00
028 COMPREHENSIVE CONSULTATION				50.00	57.00*	40.00
029 PSYCHOTHERAPY-ONE HOUR				15.00	10.00	12.50
030 PSYCHOTHERAPY-HALF HOUR				15.00	10.00	12.50
031 CHIROPRACTIC OFFICE VISIT				9.00	9.00	9.00
032 INITIAL PHYSIOTHERAPY				9.80*	8.60*	11.00
033 F/U PODIATRIC OFFICE VISIT						
034 ELECTROCARDIOGRAM (EKG)	23.00	25.00	20.00	23.00	25.00	20.00
035 EKG-INTERPRET-REPORT ONLY	12.50	6.00	12.00	12.50	6.00	12.00
036 ARTERIAL BLOOD GAS STUDY				23.00	23.00	23.00
037 ELECTROENCEPHALOGRAPH (EEG)				80.00	80.00	80.00
038 CHEMOTHERAPY				5.00	5.00	5.00
039 COLLECTION OF SPECIMENS				3.00	3.00	3.00
040 DEBRIDEMENT OF NAILS				11.00	10.00	12.00
041 SKIN BIOPSY				21.40*	25.70*	28.50*
042 CHEMOCAUTERY				45.00	30.00*	45.00
043 RADICAL WASTECTOMY				570.40*	575.00	570.40*
044 OPEN REDUCTION OF FRACTURE				450.30*	527.60*	577.50*
045 ARTHROCENTESIS-MAJOR JOINT				25.00	21.40*	21.40*
046 ARTHROTOMY				25.00	21.40*	21.40*
047 ARTHROPLASTY-REPAIR OF HIP				713.00*	713.00*	713.00*
048 NEEDLE PUNCTURE OF BURSA				17.10*	17.10	17.10*
049 BRONCHOSCOPY				110.00*	142.60	142.60*
050 THORACENTESIS	21.40*	20.00*	21.40*	35.70*	29.90*	35.70*

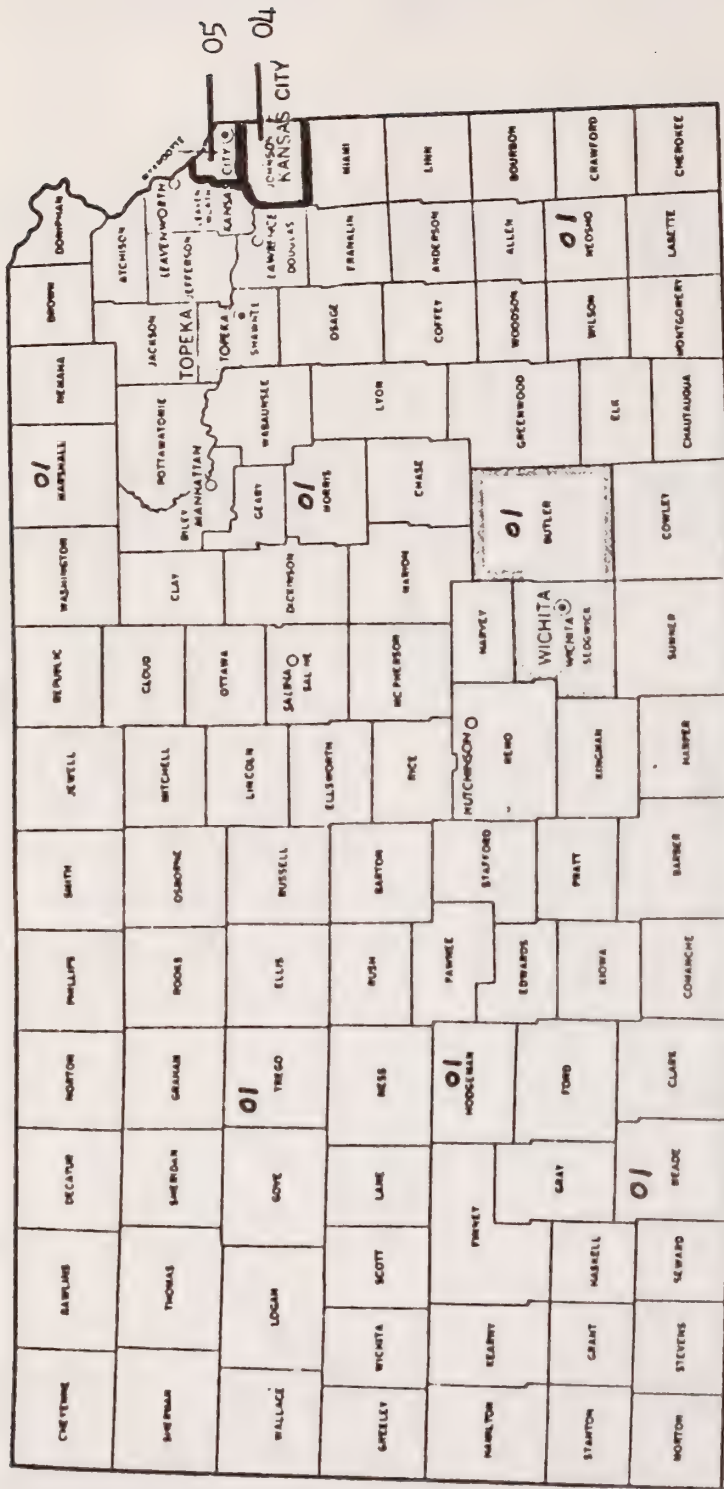
1979 PREVAILING CHARGE SUMMARY DATA S/S OF IOWA

IOWA

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	06	07	06	07
051 CATHETERIZATION OF HEART			427.80*	427.60*
052 INSERTION OF PACEMAKER			570.40*	570.40*
053 PARTIAL COLECTOMY			500.00	713.00*
054 APPENDECTOMY			320.90*	320.00
055 S.G. GYNECOLOGY			25.00	35.00
056 HEMORRHOIDECTOMY	21.40*	28.50*	245.00	249.60*
057 CHOLECYSTECTOMY			499.10	550.00
058 REPAIR HERNIA			306.00	320.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY	42.80*	42.80*	42.80*	42.80*
060 DILATION OF URETHRA			10.70*	14.30*
061 PROSTATECTOMY			570.40*	570.40*
062 ELECTROSECTION-PROSTATE (TUR)	641.70*	641.70*	641.70*	641.70*
063 HYSTERECTOMY			499.10*	534.75*
064 INITIAL COMPLETE EYE EXAM			17.10*	17.10*
065 COMPREHENSIVE EYE EXAM				16.00
066 EYE EXAM WITH TONOMETRY			641.70*	499.10*
067 EXTRACTION OF LENS	570.40*	499.10*	18.00	21.40*
068 CHEST X-RAY, SINGLE VIEW	17.10*	17.80*	25.00	21.40*
069 CHEST X-RAY, TWO VIEWS	25.00	20.00	28.50*	28.50*
070 X-RAY SPINE			21.40*	21.40*
071 X-RAY HIP			49.90*	44.50
072 X-RAY UPPER GI TRACT	35.00	35.00	45.00	45.00
073 X-RAY COLON				
074 RADIATION THERAPY-LOW VOLT				
075 RADIATION THERAPY-SUPER VOLT				
076 RADIATION THERAPY-MEGAVOLT				
077 CAT SCAN - HEAD			150.00	150.00
078 CAT SCAN-HEAD, INTERPRET ONLY			35.00	35.00
079 THREE CHEMISTRY TESTS			20.00	16.00
080 TWELVE CHEMISTRY TESTS			20.00	25.00
081 CULTURE-OTHER THAN BLOOD			7.00	10.00
082 HEWOGLOBIN				
083 AUTOMATED BLOOD COUNT				
084 WHITE CELL COUNT			4.00	3.00
085 COMPLETE BLOOD COUNT (CBC)			10.00	9.00
086 CHOLESTEROL TEST			7.00	7.50
087 FLOCCULATION TEST			6.00	6.00
088 HEMATOCRIT			4.00	3.00
089 PLATELET COUNT (REES-ECKER)			5.25	5.00
090 POTASSIUM TEST			8.00	8.00
091 PROTHROMBIN			5.00	6.00
092 SEDIMENTATION RATE			4.25	5.00
093 BLOOD SUGAR			6.25	7.00
094 BUN-UREA-NITROGEN			7.00	7.00
095 URIC ACID			7.00	8.00
096 FECES-OCCULT BLOOD			4.50	6.00
097 PAP TEST			10.00	9.00
098 ROUTINE URINALYSIS			4.00	4.00
099 CHEMICAL URINALYSIS				
100 PATHOLOGY-THREE SPECIMENS			15.00	20.00

KANSAS

KANSAS



Three Localities:

Blue Shield of Kansas

01 - Blue Shield of Kansas Plan area (102 counties)

Blue Shield of Kansas City

04 - Johnson County (suburban)

05 - Wyandotte County (metropolitan)

1979 PREVAILING CHARGE SUMMARY DATA B/S OF KANSAS CITY, MISSOURI

KANSAS

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	AREA 04	AREA 05	AREA 04	AREA 05
001 INITIAL BRIEF OFFICE VISIT			35.00	42.80*
002 INITIAL LIMITED OFFICE VISIT	35.00	25.00	35.00	42.80*
003 INIT INTERMED OFFICE VISIT			35.00	42.80*
004 INIT COMP OFFICE VISIT	35.00	25.00	35.00	42.80*
005 MINIMAL F/U OFFICE VISIT	5.00	5.00	7.10*	7.00
006 BRIEF F/U OFFICE VISIT	10.70	8.60	7.10*	7.00
007 LIMITED F/U OFFICE VISIT	10.70*	8.60*	11.30*	11.00
008 INTERMED F/U OFFICE VISIT	15.00*	18.60*	15.00	18.60*
009 EXTENDED F/U OFFICE VISIT	15.00	15.00	20.00	28.50*
010 COMPLETE F/U OFFICE VISIT	35.00	21.30*	28.50*	30.00
011 BRIEF F/U HOME VISIT	14.30*	17.10*	14.30*	17.10*
012 LIMITED F/U HOME VISIT			14.30*	17.10*
013 INTERMEDIATE F/U HOME VISIT	20.00	20.00	20.00	20.00
014 EXTENDED CARE FACILITY VISIT			20.00	15.00
015 BRIEF F/U NURSING HOME VISIT	10.70*	8.60*	11.30*	11.00*
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	35.60*	35.60*	45.00
017 INIT INTERMED HOSPITAL VISIT			49.90*	49.90*
018 INITIAL COMP HOSPITAL VISIT	35.60*	35.00	49.90*	49.90*
019 BRIEF F/U HOSPITAL VISIT	14.30**	10.00*	14.30*	14.30*
020 LIMITED F/U HOSPITAL VISIT	14.30*	10.00*	14.30*	14.30*
021 INTERMED F/U HOSPITAL VISIT	20.00	14.30*	17.10*	24.90*
022 EXTENDED F/U HOSPITAL VISIT			25.00	35.20*
023 BRIEF EMERGENCY ROOM VISIT			20.00	16.50
024 LIMITED EMERGENCY ROOM VISIT			20.00	16.50
025 INTERMED EMERGENCY ROOM VISIT			20.00	16.50
026 LIMITED CONSULTATION	35.60*	40.00	50.00	50.00
027 EXTENSIVE CONSULTATION			65.00	49.90*
028 COMPREHENSIVE CONSULTATION			65.00	49.90*
029 PSYCHOTHERAPY-ONE HOUR			45.20*	56.00
030 PSYCHOTHERAPY-HALF HOUR			22.60*	28.00
031 CHIROPRACTIC OFFICE VISIT			8.90*	8.90*
032 INITIAL PHYSIOTHERAPY			10.00	10.00
033 F/U PODIATRIC OFFICE VISIT			12.00	10.00
034 ELECTROCARDIOGRAM (EKG)	22.00	20.00	21.30*	20.00
035 EKG-INTERPRET.REPORT ONLY	9.00	9.00	8.00*	8.00*
036 ARTERIAL BLOOD GAS STUDY			8.00	8.00
037 ELECTROENCEPHALOGRAM (EEG)			65.10	85.40
038 CHEMOTHERAPY			25.50*	34.10*
039 COLLECTION OF SPECIMENS			3.00	3.00
040 DEBRIDEMENT OF NAILS			38.40*	40.00
041 SKIN BIOPSY				
042 CHEMOCAUTERY				
043 RADICAL WASTECTOMY			713.00*	727.25*
044 OPEN REDUCTION OF FRACTURE			972.50*	606.00*
045 ARTHROCENTESIS-MAJOR JOINT			25.00	15.00
046 ARTHROTOMY			25.00	15.00
047 ARTHROPLASTY-REPAIR OF HIP	18.00	12.50	900.00	750.00
048 NEEDLE PUNCTURE OF BURSA			20.00	20.00
049 BRONCHOSCOPY			125.00*	107.00*
050 THORACENTESIS			49.90*	49.90*

1979 PREVAILING CHARGE SUMMARY DATA B/S OF KANSAS CITY, MISSOURI

KANSAS

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	AREA 04	AREA 05	AREA 04	AREA 05
051 CATHETERIZATION OF HEART			373.50	405.00
052 INSERTION OF PACEMAKER			830.00	750.00
053 PARTIAL COLECTOMY			734.30*	715.00
054 APPENDECTOMY			370.80*	285.20*
055 SIGMOIDOSCOPY	21.30*	25.00	35.00	35.60*
056 HEMORRHOIDECTOMY			299.50*	285.20*
057 CHOLECYSTECTOMY			570.40*	513.40*
058 REPAIR HERNIA			390.00	315.00
059 DIAGNOSTIC CYSTOURETHROSCOPY			75.00	75.00
060 DILATION OF URETHRA	41.00	40.00	17.00	17.00
061 PROSTATECTOMY			713.00*	713.00*
062 ELECTROSECTION-PROSTATE (TUR)	656.00	640.00	641.70*	641.70*
063 HYSTERECTOMY			641.70*	591.70*
064 INITIAL COMPLETE EYE EXAM			25.00*	21.30*
065 COMPREHENSIVE EYE EXAM			25.00*	21.30*
066 EYE EXAM WITH TONOMETRY			5.70*	5.70*
067 EXTRACTION OF LENS			600.00*	625.00
068 CHEST X-RAY, SINGLE VIEW	656.00	640.00	20.00*	15.00*
069 CHEST X-RAY, TWO VIEWS	21.30*	21.30*	21.30*	21.30*
070 X-RAY SPINE	25.00		44.00	44.00
071 X-RAY HIP				28.50*
072 X-RAY UPPER GI TRACT	39.40*	34.10*	56.00	45.00*
073 X-RAY COLON			50.00	39.90*
074 RADIATION THERAPY-LOW VOLT				
075 RADIATION THERAPY-SUPER VOLT				
076 RADIATION THERAPY-MEGAVOLT				
077 CAT SCAN - HEAD			35.00	35.00
078 CAT SCAN-HEAD, INTERPRET ONLY			35.00	
079 THREE CHEMISTRY TESTS				
080 TWELVE CHEMISTRY TESTS				
081 CULTURE-OTHER THAN BLOOD			15.00	
082 HEMOGLOBIN			4.00	4.00
083 AUTOMATED BLOOD COUNT				
084 WHITE CELL COUNT			6.00	3.00
085 COMPLETE BLOOD COUNT (CBC)			10.00	9.00
086 CHOLESTEROL TEST			8.00	6.00
087 FLOCCULATION TEST				
088 HEMATOCRIT			3.00	5.00
089 PLATELET COUNT (REES-ECKER)			5.00	5.00
090 POTASSIUM TEST			8.00	8.00
091 PROTHROMBIN			4.00	6.00
092 SEDIMENTATION RATE			6.00	5.00
093 BLOOD SUGAR			7.00	6.00
094 BUN-UREA, NITROGEN			8.00	5.50
095 URIC ACID			7.00	5.50
096 FECES-OCCULT BLOOD			7.00	5.00
097 PAP TEST			9.00	10.00
098 ROUTINE URINALYSIS			6.00	5.00
099 CHEMICAL URINALYSIS				
100 PATHOLOGY-THREE SPECIMENS			6.00	5.00

COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION

SINGLE

001	INITIAL BRIEF OFFICE VISIT	10.00	001
002	INITIAL LIMITED OFFICE VISIT	20.00	002
003	INIT INTERMED OFFICE VISIT	20.00	003
004	INIT COMP OFFICE VISIT	35.00	004
005	MINIMAL F/U OFFICE VISIT	5.70*	005
006	BRIEF F/U OFFICE VISIT	10.00	006
007	LIMITED F/U OFFICE VISIT	16.00	007
008	INTERMED F/U OFFICE VISIT	20.00	008
009	EXTENDED F/U OFFICE VISIT	27.00	009
010	COMPLETE F/U OFFICE VISIT	27.00	010
011	BRIEF F/U HOME VISIT	18.00	011
012	LIMITED F/U HOME VISIT	20.00	012
013	INTERMEDIATE F/U HOME VISIT		013
014	EXTENDED CARE FACILITY VISIT		014
015	BRIEF F/U NURSING HOME VISIT	10.00	015
016	INITIAL BRIEF HOSPITAL VISIT	37.10*	016
017	INIT INTERMED HOSPITAL VISIT	37.10	017
018	INITIAL COMP HOSPITAL VISIT	57.00*	018
019	BRIEF F/U HOSPITAL VISIT	10.70*	019
020	LIMITED F/U HOSPITAL VISIT		020
021	INTERMED F/U HOSPITAL VISIT		021
022	EXTENDED F/U HOSPITAL VISIT		022
023	BRIEF EMERGENCY ROOM VISIT	25.00	023
024	LIMITED EMERGENCY ROOM VISIT	25.00	024
025	INTERMED EMERGENCY ROOM VISIT		025
026	LIMITED CONSULTATION	30.00	026
027	EXTENSIVE CONSULTATION	35.70*	027
028	COMPREHENSIVE CONSULTATION	57.00*	028
029	PSYCHOTHERAPY-ONE HOUR	50.00	029
030	PSYCHOTHERAPY-HALF HOUR	25.00	030
031	CHIROPRACTIC OFFICE VISIT	10.00	031
032	INITIAL PHYSIOTHERAPY	12.75	032
033	F/U PODIATRIC OFFICE VISIT	10.00	033
034	ELECTROCARDIOGRAM (EKG)	25.00	034
035	EKG-INTERPRET, REPORT ONLY	12.50	035
036	ARTERIAL BLOOD GAS STUDY		036
037	ELECTROENCEPHALOGRAPH (EEG)	60.00	037
038	CHEMOTHERAPY	15.00	038
039	COLLECTION OF SPECIMENS		039
040	DEBRIDEMENT OF NAILS	12.00	040
041	SKIN BIOPSY	27.00	041
042	CHEMOCAUTERY	16.00	042
043	RADICAL MASTECTOMY	650.00	043
044	OPEN REDUCTION OF FRACTURE	713.00*	044
045	ARTHROCENTESIS-MAJOR JOINT	18.80*	045
046	ARTHROTOMY	22.70*	046
047	ARTHROPLASTY-REPAIR OF HIP	1283.40*	047
048	NEEDLE PUNCTURE OF BURSA	20.00	048
049	BRONCHOSCOPY	178.25*	049
050	THORACENTESIS	35.70*	050

COMBINED LOCALITY DESIGNATION

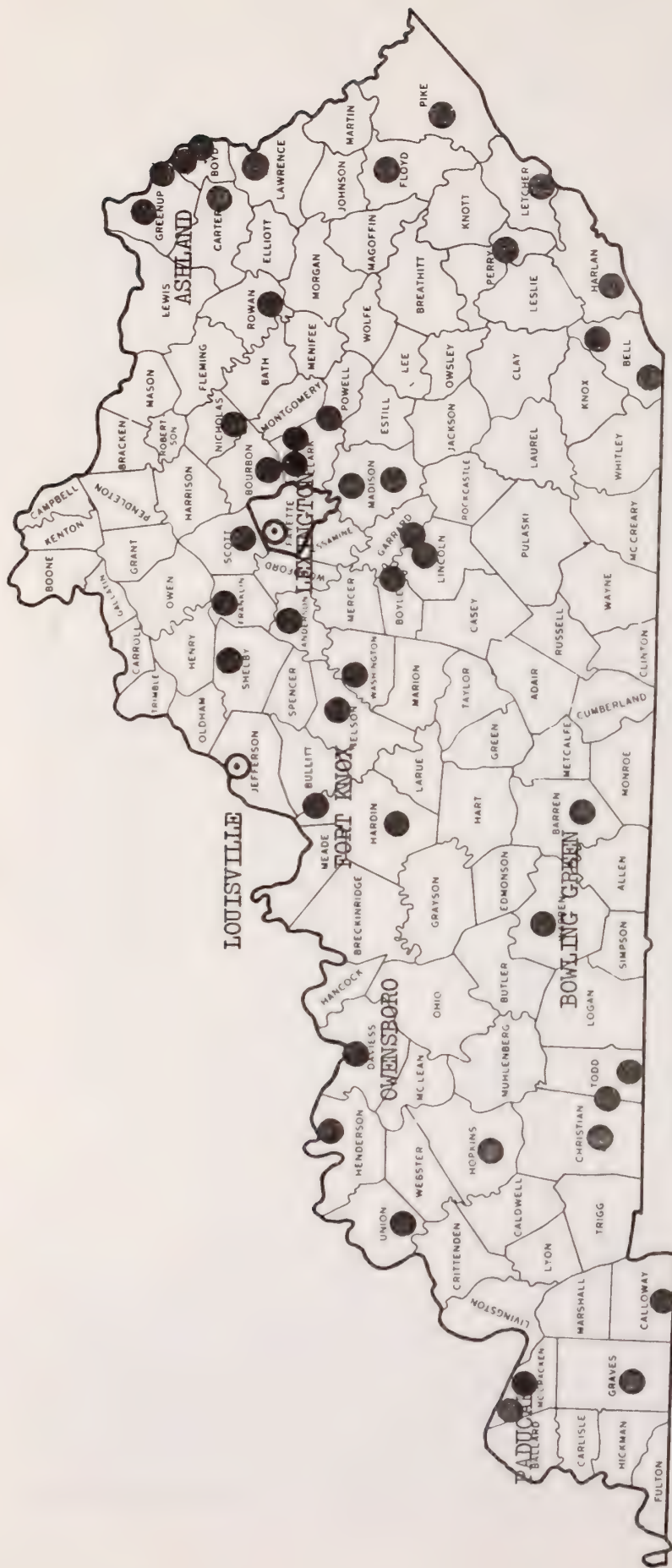
PROCEDURE DESCRIPTION

SINGLE

051	CATHERIZATION OF HEART	470.60*	051
052	INSERTION OF PACEMAKER	700.00	052
053	PARTIAL COLECTOMY	713.00*	053
054	APPENDECTOMY	299.50*	054
055	SIGMOIDOSCOPY	30.00	055
056	HEMORRHOIDECTOMY	256.70*	056
057	CHOLECYSTECTOMY	504.80*	057
058	REPAIR HERNIA	290.90*	058
059	DIAGNOSTIC CYSTOURETHROSCOPY	71.30*	059
060	DILATION OF URETHRA	20.00	060
061	PROSTATECTOMY	684.50*	061
062	ELECTROSECTION-PFOSTATE (TUR)	527.40*	062
063	HYSTERECTOMY	607.50*	063
064	INITIAL COMPLETE EYE EXAM	40.00	064
065	COMPREHENSIVE EYE EXAM	6.00	065
066	EYE EXAM WITH TONOMETRY	570.40*	066
067	EXTRACTION OF LENS	20.00	067
068	CHEST X-RAY, SINGLE VIEW	25.70*	068
069	CHEST X-RAY, TWO VIEWS	48.00	069
070	X-RAY SPINE	32.00	070
071	X-RAY HIP	56.00	071
072	X-RAY UPPER GI TRACT	50.50*	072
073	X-RAY COLON	12.50	073
074	RADIATION THERAPY-LOW VOLT	28.50*	074
075	RADIATION THERAPY-SUPER VOLT		075
076	RADIATION THERAPY-MEGAVOLT		076
077	CAT SCAN - HEAD		077
078	CAT SCAN-HEAD, INTERPRET ONLY	75.00	078
079	THREE CHEMISTRY TESTS	15.00	079
080	TWELVE CHEMISTRY TESTS	24.00	080
081	CULTURE-OTHER THAN BLOOD	13.00	081
082	HEMOGLOBIN	4.00	082
083	AUTOMATED BLOOD COUNT		083
084	WHITE CELL COUNT	5.00	084
085	COMPLETE BLOOD COUNT (CBC)	11.00	085
086	CHOLESTEROL TEST	9.00	086
087	FLOCCULATION TEST	6.00	087
088	HEMATOCRIT	4.00	088
089	PLATELET COUNT (REES-ECKER)	6.00	089
090	POTASSIUM TEST	8.00	090
091	PROTHROMBIN	7.00	091
092	SEDIMENTATION RATE	5.00	092
093	BLOOD SUGAR	7.00	093
094	BUN-UREA, NITROGEN	9.00	094
095	URIC ACID	9.00	095
096	FECES-OCCULT BLOOD	3.33	096
097	PAP TEST	12.00	097
098	ROUTINE URINALYSIS	5.00	098
099	CHEMICAL URINALYSIS	5.00	099
100	PATHOLOGY-THREE SPECIMENS		100

KENTUCKY

KENTUCKY



Three Localities:

- I - Metropolitan- Lexington (Fayette County), Louisville (including Anchorage, Crestwood, Jeffersontown, Lyndon, Middletown, Okalona, Pee Wee Valley, Pleasure Ridge Park, Shively, St. Matthews, Valley Station).
- II -Urban- Ashland(including Grayson, Greenup, Westwood), Bardstow, Bellevue, Bowling Green, Catlettsburg, Covington (including Alexandria, Bromley, Burlington, Dayton, Elsmere Park, Ft. Mitchell, South Hills, Southgate, Walton, Woodlawn), Danville, Elizabethtown (including Lebanon Junction), Florence, Fort Thomas, Frankfort(including Midway), Georgetown, Glasgow, Harlan, Hazard (including Whitesburg), Henderson, Hopkinsville (including Elkton, Fairview), Lancaster, Lawrenceburg, Louisa, Madisonville, Mayfield, Middlesboro, Morehead, Morganfield, Mount Sterling, Murray, Newport, Nicholasville, Owensboro, Paducah (including West Paducah), Paris, Pikeville, Pineville, Prestonsburg, Richmond, Shelbyville, Stanford, Versailles, Vine Grove, Winchester(including Carlisle, Stanton).
- III -Rural- All other areas of the State.

rest of state

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	I	II	III	I	II	III
001 INITIAL BRIEF OFFICE VISIT	31.40	15.00	25.00	21.40	14.30	14.30
002 INITIAL LIMITED OFFICE VISIT				35.70	30.00	25.00
003 INIT INTERMED OFFICE VISIT	25.00	30.00	30.00	35.90	30.00	25.00
004 INIT COMP OFFICE VISIT	6.00	5.70	5.70	49.90	42.80	37.00
005 MINIMAL F/U OFFICE VISIT	10.00	8.60	7.10	7.00	8.00	5.70
006 BRIEF F/U OFFICE VISIT	13.00	12.00	11.40	11.40	11.40	8.60
007 LIMITED F/U OFFICE VISIT	9.00	17.10	15.00	14.30	13.00	12.00
008 INTERMED F/U OFFICE VISIT	20.00	17.00	20.00	20.00	16.00	14.30
009 EXTENDED F/U OFFICE VISIT	24.00	24.00	24.00	25.00	21.40	21.40
010 COMPLETE F/U OFFICE VISIT	17.10	14.30	14.30	40.00	35.70	32.00
011 BRIEF F/U HOME VISIT				17.10	15.00	14.30
012 LIMITED F/U HOME VISIT	20.00	20.00	21.40	21.40	25.00	25.00
013 INTERMEDIATE F/U HOME VISIT				21.40	25.00	25.00
014 EXTENDED CARE FACILITY VISIT	10.00	8.60	7.10	14.30	14.30	11.40
015 BRIEF F/U NURSING HOME VISIT	28.50	21.40	21.40	11.40	11.40	8.60
016 INITIAL BRIEF HOSPITAL VISIT				35.70	21.40	21.40
017 INIT INTERMED HOSPITAL VISIT	49.90	35.00	35.00	40.00	35.70	30.00
018 INITIAL COMP HOSPITAL VISIT	13.30	10.00	8.60	55.00	49.90	44.00
019 BRIEF F/U HOSPITAL VISIT	14.30	14.30	14.30	14.30	11.40	10.00
020 LIMITED F/U HOSPITAL VISIT	14.30	14.30	14.30	14.30	14.30	14.30
021 INTERMED F/U HOSPITAL VISIT				14.30	14.30	14.30
022 EXTENDED F/U HOSPITAL VISIT				21.40	25.00	20.00
023 BRIEF EMERGENCY ROOM VISIT	30.00	35.00	35.00	21.40	14.30	14.30
024 LIMITED EMERGENCY ROOM VISIT				32.00	35.70	30.00
025 INTERMED EMERGENCY ROOM VISIT				35.70	35.70	35.70
026 LIMITED CONSULTATION				35.00	40.00	35.00
027 EXTENSIVE CONSULTATION				50.00	49.90	25.00
028 COMPREHENSIVE CONSULTATION				20.40	21.40	17.10
029 PSYCHOTHERAPY-ONE HOUR				20.40	21.40	17.10
030 PSYCHOTHERAPY-HALF HOUR				20.40	21.40	17.10
031 CHIROPRACTIC OFFICE VISIT	10.00	8.60	7.10	10.00	8.60	7.10
032 INITIAL PHYSIOTHERAPY				21.40	14.30	14.30
033 F/U PODIATRIC OFFICE VISIT	20.00	20.00	20.00	11.40	11.40	8.60
034 ELECTROCARDIOGRAM (EKG)	7.00	7.20	7.10	20.00	20.00	20.00
035 EKG-INTERPRET, REPORT ONLY				7.00	7.20	7.00
036 ARTERIAL BLOOD GAS STUDY				27.50	27.50	27.50
037 ELECTROENCEPHALOGRAM (EEG)				42.80	46.00	46.00
038 CHEMOTHERAPY						
039 COLLECTION OF SPECIMENS				1.40	1.40	1.40
040 DEBRIDEMENT OF NAILS				15.00	12.00	12.00
041 SKIN BIOPSY				35.00	30.00	35.00
042 CHEMOCAUTERY				15.00	11.70	10.00
043 RADICAL MASTECTOMY				696.00	641.70	570.40
044 OPEN REDUCTION OF FRACTURE				820.00	713.00	720.00
045 ARTHROCENTESIS-MAJOR JOINT				21.00	15.00	15.00
046 ARTHROTOMY				21.00	15.00	15.00
047 ARTHROPLASTY-REPAIR OF HIP	15.00	14.30	12.00	1500.00	1650.00	15.00
048 NEEDLE PUNCTURE OF BURSA				15.00	15.00	15.00
049 BRONCHOSCOPY				142.60	150.00	107.00
050 THORACENTESIS				35.70	40.00	35.70

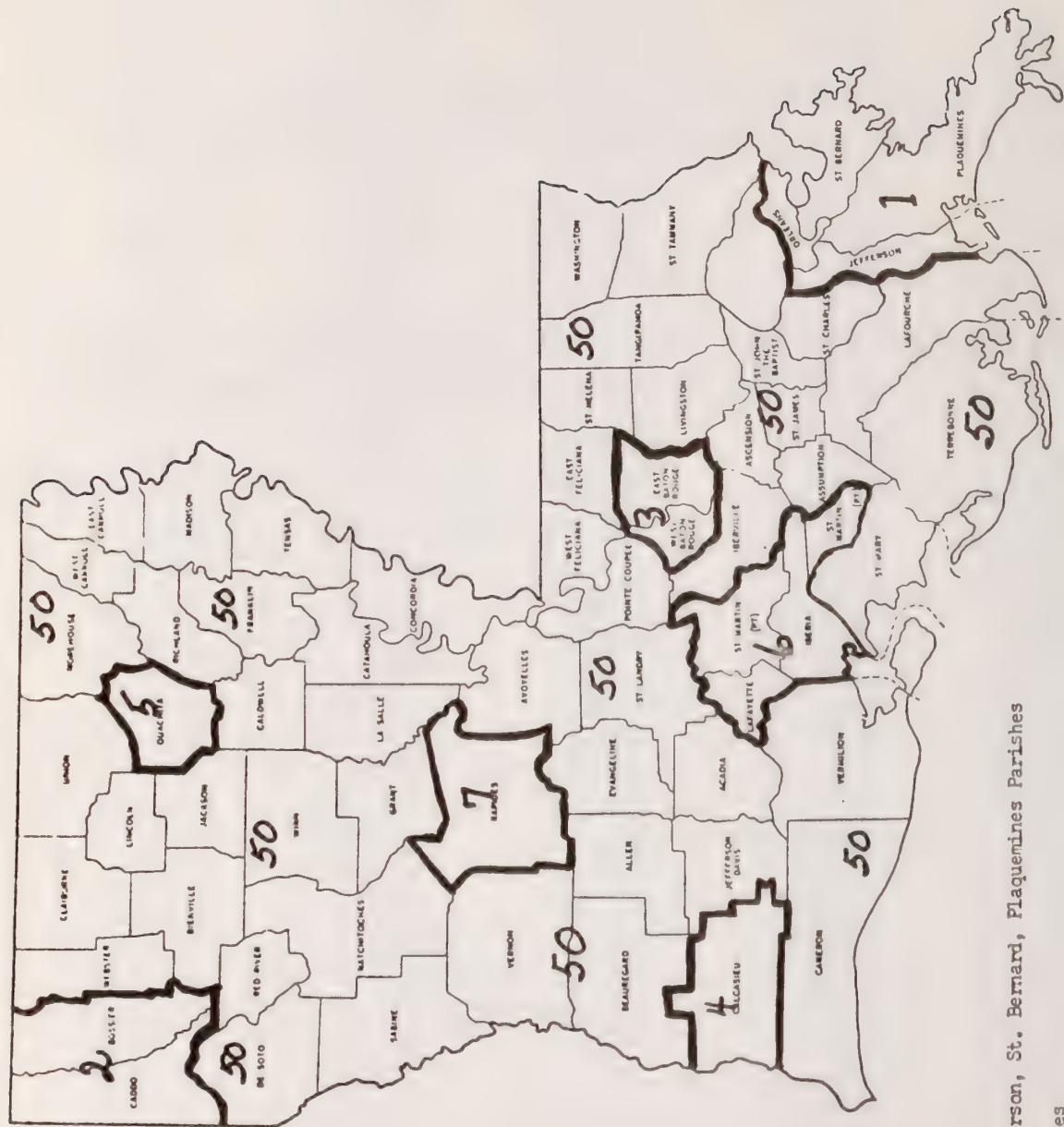
1979 PREVAILING CHARGE SUMMARY DATA METROPOLITAN LIFE INSURANCE CO.

KENTUCKY

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	I	II	III	I	II	III
051 CATHETERIZATION OF HEART				433.20	400.50	373.50
052 INSERTION OF PACEMAKER				713.00	750.00	830.00
053 PARTIAL COLECTOMY				713.00	713.00	713.00
054 APPENDECTOMY				356.50	356.50	356.50
055 SIGMOIDOSCOPY	21.40	20.00	25.00	25.00	28.50	30.00
056 HEMORRHOIDECTOMY				330.00	285.20	249.60
057 CHOLECYSTECTOMY				534.80	499.10	499.10
058 REPAIR HERNIA				350.00	350.00	285.20
059 DIAGNOSTIC CYSTOURETHROSCOPY	35.70	35.70	35.70	35.70	42.50	35.70
060 DILATION OF URETHRA				15.00	14.30	15.00
061 PROSTATECTOMY				600.00	560.00	640.00
062 ELECTROSECTION-PROSTATE (TUR)	570.40	570.40	570.40	570.40	570.40	570.40
063 HYSTERECTOMY				641.70	606.10	499.10
064 INITIAL COMPLETE EYE EXAM				28.00	21.40	25.00
065 COMPREHENSIVE EYE EXAM				28.00	21.40	25.00
066 EYE EXAM WITH TONOMETRY				14.00	8.60	7.10
067 EXTRACTION OF LENS	570.40	570.40	570.40	570.40	570.40	570.40
068 CHEST X-RAY, SINGLE VIEW	17.00	14.30	14.30	20.00	20.00	14.30
069 CHEST X-RAY, TWO VIEWS	18.00	20.00	21.40	21.40	20.00	21.40
070 X-RAY SPINE				31.00	30.00	30.00
071 X-RAY HIP				24.00	21.40	24.00
072 X-RAY UPPER GI TRACT	42.80	42.80	35.70	45.00	40.00	45.00
073 X-RAY COLON				42.80	40.00	36.00
074 RADIATION THERAPY-LOW VOLT	15.00	15.00		15.00	15.00	
075 RADIATION THERAPY-SUPER VOLT	28.50	25.80		27.50	27.50	
076 RADIATION THERAPY-MEGAVOLT				27.50	27.50	
077 CAT SCAN - HEAD				150.00	150.00	150.00
078 CAT SCAN-HEAD, INTERPRET ONLY						
079 THREE CHEMISTRY TESTS				10.50	10.50	10.50
080 TWELVE CHEMISTRY TESTS				12.60	12.60	12.60
081 CULTURE-OTHER THAN BLOOD				10.00	10.00	8.00
082 HEMOGLOBIN				4.00	3.00	3.00
083 AUTOMATED BLOOD COUNT				1.50	2.00	2.00
084 WHITE CELL COUNT				4.00	3.00	3.00
085 COMPLETE BLOOD COUNT (CBC)				8.00	7.50	8.00
086 CHOLESTEROL TEST				7.00	7.00	8.00
087 FLOCCULATION TEST				4.00	4.00	4.00
088 HEMATOCRIT				3.00	3.00	4.00
089 PLATELET COUNT (REES-ECKER)				6.00	5.50	6.00
090 POTASSIUM TEST				8.00	7.00	6.00
091 PROTHROMBIN				6.00	6.00	6.00
092 SEDIMENTATION RATE				5.00	5.00	5.00
093 BLOOD SUGAR				6.00	6.50	6.00
094 EJN-UREA, NITROGEN				8.00	7.00	8.00
095 URIC ACID				7.50	8.00	7.50
096 FECES-OCCULT BLOOD				3.00	3.00	3.30
097 PAP TEST				8.00	10.00	10.00
098 ROUTINE URINALYSIS				5.00	4.00	4.00
099 CHEMICAL URINALYSIS				4.00	3.00	3.00
100 PATHOLOGY-THREE SPECIMENS				11.40	14.30	16.00

LOUISIANA

LOUISIANA



Eight Localities:

01 - Orleans Parish, Jefferson, St. Bernard, Plaquemines Parishes

02 - Caddo, Bossier Parishes

03 - East Baton Rouge, West Baton Rouge Parishes

04 - Calcasieu Parish

05 - Ouachita Parish

06 - Lafayette, Iberia, St. Martin Parishes

07 - Rapides Parish

50 - All other Parishes

1979 PREVAILING CHARGE SUMMARY DATA

PAN-AMERICAN LIFE INSURANCE CO.

LOUISIANA

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	01	02	03	04	05	01	02	03	04	05
001 INITIAL BRIEF OFFICE VISIT		17.90*	20.00	20.00	21.00	35.60*	35.60*	35.00	35.60*	35.00
002 INITIAL LIMITED OFFICE VISIT						35.60*	35.60*	35.00	35.60*	35.00
003 INIT INTERMED OFFICE VISIT						35.60*	35.60*	35.00	35.60*	35.00
004 INIT COMP OFFICE VISIT	20.00	17.90	20.00	20.00	21.00	35.60*	35.60*	35.00	35.60*	35.00
005 MINIMAL F/U OFFICE VISIT	6.00	4.20*	4.20*	7.00	4.20*	7.10*	5.00	5.00*	8.00	7.00
006 BRIEF F/U OFFICE VISIT	10.00	8.60*	10.00	7.10*	7.10*	11.30*	10.00*	11.30*	11.30*	11.30*
007 LIMITED F/U OFFICE VISIT	14.30*	14.30*	15.00	10.00*	20.00	14.30*	21.30*	14.30*	14.30*	14.30*
008 INTERMED F/U OFFICE VISIT	14.30*	14.30*	15.00	10.00*	20.00	14.30*	21.30*	14.30*	14.30*	14.30*
009 EXTENDED F/U OFFICE VISIT	14.30*	14.30*	15.00	10.00*	20.00	14.30*	21.30*	14.30*	14.30*	14.30*
010 COMPLETE F/U OFFICE VISIT	10.00	10.00	10.00	10.00	10.00	10.70*	12.50*	11.90*	10.70*	10.70*
011 BRIEF F/U HOME VISIT	17.10*	15.00	10.00	14.30*	11.30*	17.10*	15.00	10.00	14.30*	11.30*
012 LIMITED F/U HOME VISIT						20.00	20.00	20.00	20.00	20.00
013 INTERMEDIATE F/U HOME VISIT	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00
014 EXTENDED CARE FACILITY VISIT						15.00	15.00	14.30*	14.30*	14.30*
015 BRIEF F/U NURSING HOME VISIT	10.00*	8.60*	10.00	7.10	7.10*	11.30*	10.00	11.30*	11.30*	11.30*
016 INITIAL BRIEF HOSPITAL VISIT	35.60	35.00	25.00	21.30*	30.00	35.60*	49.90*	35.00	35.60*	35.60*
017 INIT INTERMED HOSPITAL VISIT						49.90*	50.00	49.90*	50.00	50.00
018 INITIAL COMP HOSPITAL VISIT	50.00	50.00	49.90*	40.00	35.60*	49.90*	50.00	49.90*	50.00	50.00
019 BRIEF F/U HOSPITAL VISIT	14.30*	10.00	11.30*	14.30*	14.60*	17.10*	15.00	14.30*	15.00	14.30*
020 LIMITED F/U HOSPITAL VISIT	25.00	18.75	25.00	28.50*	25.00	25.00	25.00	20.00	35.00	30.00
021 INTERMED F/U HOSPITAL VISIT	25.00	18.75	25.00	28.50*	25.00	25.00	25.00	20.00	35.00	30.00
022 EXTENDED F/U HOSPITAL VISIT						25.00	25.00	20.00	35.00	30.00
023 BRIEF EMERGENCY ROOM VISIT						29.50*	25.00	20.00	29.00*	25.00
024 LIMITED EMERGENCY ROOM VISIT						49.90*	50.00	49.90*	50.00	50.00
025 INTERMED EMERGENCY ROOM VISIT						12.50	12.50*	12.50*	15.00	10.70
026 LIMITED CONSULTATION	35.60*	40.00	40.00	40.00	35.00	49.90*	45.00	35.60*	49.90*	35.60*
027 EXTENSIVE CONSULTATION						71.40	75.00	45.00	50.00	50.00
028 COMPREHENSIVE CONSULTATION						5.00	5.00	4.40	5.00	5.00
029 PSYCHOTHERAPY-ONE HOUR						5.00	5.00	4.40	5.00	5.00
030 PSYCHOTHERAPY-HALF HOUR						10.00	8.00	10.00	8.00	10.00
031 CHIROPRACTIC OFFICE VISIT	10.00	8.60	10.00	7.10*	7.10*					
032 INITIAL PHYSIOTHERAPY										
033 F/U PODIATRIC OFFICE VISIT						12.00	14.30*	12.80*	12.80*	12.80*
034 ELECTROCARDIOGRAM (EKG)	20.00	18.00	25.00	20.00	20.00	20.00	18.00	25.00	20.00	20.00
035 EKG-INTERPRET-REPORT ONLY	6.00	10.70*	10.70*	10.25	10.25	8.00	20.00	20.00	10.25	10.25
036 ARTERIAL BLOOD GAS STUDY						20.00	19.90	19.90	19.90*	19.90*
037 ELECTROENCEPHALOGRAPH (EEG)						42.00	49.80*	42.00	42.00	42.00
038 CHEMOTHERAPY										
039 COLLECTION OF SPECIMENS										
040 DEBRIDEMENT OF NAILS						15.00	15.00	15.00	13.70	13.50*
041 SKIN BIOPSY						28.50*	35.60*	35.00	28.50*	21.30*
042 CHEMOCAUTERY						15.00	15.00	15.00	15.00	15.00
043 RADICAL MASTECTOMY						850.00	641.80*	713.00*	713.00*	641.80*
044 OPEN REDUCTION OF FRACTURE						784.40*	713.00*	713.00*	713.00*	713.00*
045 ARTHROCENTESIS-MAJOR JOINT						20.00	20.00	20.00	20.00	20.00
046 ARTHROTOMY						14.30	20.00	14.30*	20.00	14.30*
047 ARTHROPLASTY-REPAIR OF HIP						784.40*	855.60*	750.00	784.40*	748.40*
048 NEEDLE PUNCTURE OF BURSA						12.00	12.00	12.00	12.00	12.00
049 BRONCHOSCOPY						200.00	150.00	178.20*	178.20*	178.20*
050 THORACENTESIS	10.00	15.00	14.30*	15.00	12.00	71.40*	71.40*	71.40*	71.40*	75.00

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	01	02	03	04	05	01	02	03	04	05
051 CATHETERIZATION OF HEART	550.00					550.00	550.00	392.20*	392.20*	392.20*
052 INSERTION OF PACEMAKER	700.00					700.00	700.00	644.90*	700.00	644.90*
053 PERICARDIAL COLECTOMY	900.00					900.00	750.00*	600.00	713.00*	750.00
054 PERICARDIOTOMY	350.00					350.00	350.00	350.00	350.00	350.00
055 PERICARDIOTOMY	35.00	28.50*		35.00	35.00	35.00	25.00	21.30*	35.60*	28.50*
056 PERICARDIOTOMY	380.00					380.00	325.00	356.50*	356.50*	356.50*
057 PERICARDIOTOMY	700.00					700.00	499.20*	499.20*	499.20*	499.20*
058 PERICARDIOTOMY	450.00					450.00	356.50*	350.00	300.00	350.00
059 PERICARDIOTOMY	51.00*					51.00*	38.00	49.90*	49.90*	49.90*
060 PERICARDIOTOMY	14.00*					14.00*	15.00	7.00	10.00	10.00
061 PERICARDIOTOMY	700.00					700.00	713.00*	713.00*	688.60*	713.00*
062 PERICARDIOTOMY	713.00*					713.00*	606.10	684.60*	641.80*	641.80*
063 PERICARDIOTOMY	750.00					750.00	700.00	570.40*	700.00	700.00
064 PERICARDIOTOMY	21.00*					21.00*	19.00*	24.00	23.50*	20.00
065 PERICARDIOTOMY										
066 PERICARDIOTOMY	12.00					12.00	10.00	11.30*	10.00	10.00*
067 PERICARDIOTOMY	713.00*					713.00*	713.00	583.00	570.40*	570.40*
068 PERICARDIOTOMY	20.00					20.00	20.00	20.00	20.00	20.00
069 PERICARDIOTOMY	24.90*	24.90*	21.30*	24.90*	24.90*	25.70*	25.70*	25.70*	20.00	25.70*
070 X-RAY SPINE						48.00	45.00	45.00	45.00	45.00
071 X-RAY HIP						20.00*	23.50*	35.00	37.90	28.50*
072 X-RAY UPPER GI TRACT	49.90*	49.90*	49.90*	60.00	45.90*	57.00	55.00	55.00	50.00	55.00
073 X-RAY COLON						50.00	55.00	50.00	49.90*	55.00
074 RADIATION THERAPY-LOW VOLT	22.10*	19.90*	22.20*	20.00	20.00	20.90*	20.00	20.00	20.00	20.00
075 RADIATION THERAPY-SUPER VOLT	18.70*	24.00*	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00
076 RADIATION THERAPY-MEGAVOLT						35.00	35.00	35.00	35.00	35.00
077 CAT SCAN - HEAD						150.00	150.00	150.00	150.00	150.00
078 CAT SCAN-HEAD-INTERPRET ONLY										
079 CAT SCAN-HEAD-INTERPRET ONLY										
080 CAT SCAN-HEAD-INTERPRET ONLY										
081 CAT SCAN-HEAD-INTERPRET ONLY										
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098 CAT SCAN-HEAD-INTERPRET ONLY										
099 CAT SCAN-HEAD-INTERPRET ONLY										
100 CAT SCAN-HEAD-INTERPRET ONLY										

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	06	07	50	06	07	50
001 INITIAL BRIEF OFFICE VISIT				35.00	35.00	25.00
002 INITIAL LIMITED OFFICE VISIT	15.00	17.10*	17.10*	35.00	35.00	25.00
003 INIT INTERMED OFFICE VISIT				35.00	35.00	25.00
004 INIT COMP OFFICE VISIT	15.00	17.10*	17.10*	35.00	35.00	25.00
005 MINIMAL F/U OFFICE VISIT	8.00	5.00	4.20*	5.00	7.00	5.00
006 BRIEF F/U OFFICE VISIT	7.10*	8.60*	7.10*	11.30*	11.30*	10.00
007 LIMITED F/U OFFICE VISIT	14.30*	11.30*	11.30*	15.00	14.30*	14.30*
008 INTERMED F/U OFFICE VISIT	14.30*	11.30*	11.30*	15.00	14.30*	14.30*
009 EXTENDED F/U OFFICE VISIT	14.30*	11.30*	11.30*	15.00	14.30*	14.30*
010 COMPLETE F/U OFFICE VISIT	10.00	10.00*	8.90*	10.70	10.70*	8.90*
011 BRIEF F/U HOME VISIT	14.30*	15.00	14.30*	14.30*	15.00	14.30*
012 LIMITED F/U HOME VISIT				20.00	20.00	20.00
013 INTERMEDIATE F/U HOME VISIT	20.00	20.00	20.00	20.00	20.00	20.00
014 EXTENDED CARE FACILITY VISIT				14.30*	14.30*	14.30*
015 BRIEF F/U NURSING HOME VISIT	7.10*	8.60*	7.10*	11.30*	11.30*	10.00
016 INITIAL BRIEF HOSPITAL VISIT	25.00	21.30*	28.50*	35.00	35.00	35.60*
017 INIT INTERMED HOSPITAL VISIT				40.00	50.00	50.00
018 INITIAL COMP HOSPITAL VISIT	35.00	40.00	35.00	40.00	50.00	50.00
019 BRIEF F/U HOSPITAL VISIT	14.30*	10.00	12.00	14.00	17.10*	15.00
020 LIMITED F/U HOSPITAL VISIT	20.00	25.00	35.00	23.10*	35.00	28.50*
021 INTERMED F/U HOSPITAL VISIT	20.00	25.00	35.00	23.10*	35.00	28.50*
022 EXTENDED F/U HOSPITAL VISIT				23.10*	35.00	28.50*
023 BRIEF EMERGENCY ROOM VISIT				20.00	14.30*	21.30*
024 LIMITED EMERGENCY ROOM VISIT				40.00	50.00	50.00
025 INTERMED EMERGENCY ROOM VISIT				12.50	12.50*	8.90*
026 LIMITED CONSULTATION	35.60*	28.50*	35.60*	35.00	35.00	35.60*
027 EXTENSIVE CONSULTATION				40.00	49.90*	49.90*
028 COMPREHENSIVE CONSULTATION						
029 PSYCHOTHERAPY-ONE HOUR				5.00	5.00	4.20
030 PSYCHOTHERAPY-HALF HOUR				5.00	5.00	4.20
031 CHIROPRACTIC OFFICE VISIT	7.10*	8.60*	7.10*	10.00	8.00	10.00
032 INITIAL PHYSIOTHERAPY						
033 F/U PODIATRIC OFFICE VISIT				12.50*	12.80*	11.30*
034 ELECTROCARDIOGRAM (EXG)	20.00	20.00	20.00	20.00	20.00	20.00
035 EKG-INTERPRET. REPORT ONLY	10.25	10.25	10.25	10.25	10.25	10.25
036 ARTERIAL BLOOD GAS STUDY				19.90*	19.90*	19.90*
037 ELECTROENCEPHALOGRAPH (EEG)				42.00	42.00	42.00
038 CHEMOTHERAPY						
039 COLLECTION OF SPECIMENS						
040 DEBRIDEMENT OF NAILS				15.00	14.40*	15.00
041 SKIN BIOPSY				25.00	21.30	35.60*
042 CHEMOCAUTERY				15.00	15.00	15.00
043 RADICAL MASTECTOMY				713.00*	713.00*	606.10*
044 OPEN REDUCTION OF FRACTURE				713.00*	713.00*	713.00*
045 ARTHROCENTESIS-MAJOR JOINT				20.00	20.00	18.90*
046 ARTHROTOMY				15.00	14.30*	15.00
047 ARTHROPLASTY-REPAIR OF HIP				784.40*	677.40*	784.40*
048 NEEDLE PUNCTURE OF BURSA				12.00	12.00	12.00
049 BRONCHOSCOPY				178.20*	178.20*	175.00
050 THORACENTESIS				71.40*	75.00	50.00

1979 PREVAILING CHARGE SUMMARY DATA PAN-AMERICAN LIFE INSURANCE CO. LOUISIANA

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	06	07	50	06	07	50
051 CATHETERIZATION OF HEART				493.40*	392.20*	392.20*
052 INSERTION OF PACEMAKER				700.00	700.00	700.00
053 PARTIAL COLECTOMY				641.80*	713.00*	713.00*
054 APPENDECTOMY				350.00	350.00	350.00
055 SIGMOIDOSCOPY	28.50*	35.00	28.50*	28.50*	28.50*	35.60*
056 HEMORRHOIDECTOMY				356.50*	356.50*	350.00
057 CHOLECYSTECTOMY				450.00	600.00	499.20*
058 REPAIR HERNIA				335.00	363.00	350.00
059 DIAGNOSTIC CYSTOURETHROSCOPY	49.90*		57.00	40.00	47.00	57.00*
060 DILATION OF URETHRA				10.00	9.00	21.30*
061 PROSTATECTOMY				641.00*	713.00*	713.00*
062 ELECTROSECTION-PROSTATE (TUR)	541.80*	641.80*	570.40*	570.00*	641.80*	641.80*
063 HYSTERECTOMY				700.00	700.00	570.40*
064 INITIAL COMPLETE EYE EXAM				20.00	21.60	20.00
065 COMPREHENSIVE EYE EXAM						
066 EYE EXAM WITH TONOMETRY				7.50	7.10*	12.00
067 EXTRACTION OF LENS	641.80*	641.80*	641.80*	650.00	600.00	641.80*
068 CHEST X-RAY, SINGLE VIEW	16.00	15.00	17.10*	20.00	20.00	18.00
069 CHEST X-RAY, TWO VIEWS	22.80*	24.90*	25.00	25.70*	25.70*	21.30*
070 X-RAY SPINE				45.00	45.00	45.00
071 X-RAY HIP				33.00	28.50*	28.50*
072 X-RAY UPPER GI TRACT	49.90*	49.90*	57.00*	49.90*	55.00	44.00
073 X-RAY COLON				55.00	55.00	42.80*
074 RADIATION THERAPY-LOW VOLT	20.00	20.00	20.00	20.00	20.00	20.00
075 RADIATION THERAPY-SUPER VOLT	25.00	25.00	25.00	25.00	25.00	25.00
076 RADIATION THERAPY-MEGAVOLT				35.00	35.00	35.00
077 CAT SCAN - HEAD				150.00	150.00	150.00
078 CAT SCAN-HEAD, INTERPRET ONLY						
079 THREE CHEMISTRY TESTS				25.00	20.00	32.00
080 TWELVE CHEMISTRY TESTS				10.00	14.00	8.00
081 CULTURE-OTHER THAN BLOOD				5.00	3.00	3.75
082 HEMOGLOBIN				8.00	9.00	10.00
083 AUTOMATED BLOOD COUNT				4.00	6.00	4.00
084 WHITE CELL COUNT				8.00	9.00	10.00
085 COMPLETE BLOOD COUNT (CBC)				6.00	7.00	8.00
086 CHOLESTEROL TEST				5.00	7.00	8.00
087 FLOCCULATION TEST				3.00	3.00	4.00
088 HEMATOCRIT				6.00	7.00	7.00
089 PLATELET COUNT (REES-ECKER)				5.30	6.00	7.00
090 POTASSIUM TEST				6.00	7.00	6.00
091 PROTHROMBIN				5.00	6.00	7.00
092 SEDIMENTATION RATE				8.00	7.00	8.00
093 BLOOD SUGAR				6.00	7.00	8.00
094 BUN-UREA,NITROGEN				7.00	7.00	9.00
095 URIC ACID				4.00	4.50	5.00
096 FECES-OCCULT BLOOD				6.00	10.00	10.00
097 PAP TEST				5.00	5.00	4.00
098 ROUTINE URINALYSIS				3.00	5.00	4.00
099 CHEMICAL URINALYSIS				15.00	13.00	18.00
100 PATHOLOGY-THREE SPECIMENS						

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Three Localities:

- 01 - Northern Maine - Aroostook, Piscataquis, Penobscot, Washington, Hancock, Waldo, Somerset and Franklin Counties
- 02 - Central Maine - Oxford, Androscoggin, Kennebec, Sagadahoc, Lincoln, and Knox Counties
- 03 - Southern Maine - Cumberland and York Counties

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	AREA 01	AREA 02	AREA 03	AREA 01	AREA 02	AREA 03
001 INITIAL BRIEF OFFICE VISIT	21.40	15.00	25.00	14.30*	15.00	15.00
002 INITIAL LIMITED OFFICE VISIT				25.00	30.00	35.70*
003 INIT INTERMED OFFICE VISIT	35.70*	25.00	25.00	43.00	42.00	30.00
004 INIT COMP OFFICE VISIT	5.70*	6.00	5.70*	35.00	35.70*	35.70*
005 MINIMAL F/U OFFICE VISIT	8.60*	10.00	10.00	7.10*	7.10*	5.70*
006 BRIEF F/U OFFICE VISIT	10.00	14.30*	12.00	11.00	11.40*	11.40*
007 LIMITED F/U OFFICE VISIT	14.30*	14.20*	11.00	15.00	14.30*	12.00
008 INTERMED F/U OFFICE VISIT	15.00	15.00	15.00	21.40*	20.00	25.00
009 EXTENDED F/U OFFICE VISIT	30.80*	33.70*	31.40*	35.00	23.60	23.60
010 COMPLETE F/U OFFICE VISIT	14.00	14.30*	12.00	16.00	20.00	15.00
011 BRIEF F/U HOME VISIT				30.00	30.00	20.00
012 LIMITED F/U HOME VISIT						
013 INTERMEDIATE F/U HOME VISIT						
014 EXTENDED CARE FACILITY VISIT	7.50	8.00	8.00	10.00	10.00	10.00
015 BRIEF F/U NURSING HOME VISIT	21.40*	21.40*	21.40*	30.00	30.00	20.00
016 INITIAL BRIEF HOSPITAL VISIT				35.00	40.00	35.70*
017 INIT INTERMED HOSPITAL VISIT	30.00	30.00	30.00	40.00	45.00	40.00
018 INITIAL COMP HOSPITAL VISIT	10.00	10.00	10.00	12.00	12.80*	11.40*
019 BRIEF F/U HOSPITAL VISIT	10.00	14.30*	14.30*	10.00	16.00	14.30*
020 LIMITED F/U HOSPITAL VISIT	14.30*	22.00	22.00	14.30	16.00	25.00
021 INTERMED F/U HOSPITAL VISIT				25.00	20.00	25.00
022 EXTENDED F/U HOSPITAL VISIT						
023 BRIEF EMERGENCY ROOM VISIT						
024 LIMITED EMERGENCY ROOM VISIT						
025 INTERMED EMERGENCY ROOM VISIT	21.90*	21.40*	24.00	28.00	29.10*	25.00*
026 LIMITED CONSULTATION				35.00	35.00	35.70*
027 EXTENSIVE CONSULTATION				50.00	50.00	40.00
028 COMPREHENSIVE CONSULTATION				45.00	45.00	45.00
029 PSYCHOTHERAPY-ONE HOUR				30.00	30.00	30.00
030 PSYCHOTHERAPY-HALF HOUR						
031 CHIROPRACTIC OFFICE VISIT	7.70*	10.00	7.80*			
032 INITIAL PHYSIOTHERAPY						
033 F/U PODIATRIC OFFICE VISIT	18.00	18.00	20.00	12.00	12.00	12.00
034 ELECTROCARDIOGRAM (EKG)	9.00	9.00	10.00	19.25*	21.50	21.50
035 EKG-INTERPRET, REPORT ONLY				9.00	10.00	10.00
036 ARTERIAL BLOOD GAS STUDY						
037 ELECTROENCEPHALOGRAPH (EEG)				55.00	55.00	55.00
038 CHEMOTHERAPY				15.00	12.00	15.00
039 COLLECTION OF SPECIMENS				15.00	14.80*	15.00
040 DEBRIDEMENT OF NAILS				25.00	25.00	21.40*
041 SKIN BIOPSY						
042 CHEMOCAUTERY						
043 RADICAL MASTECTOMY				590.90*	598.90*	570.40*
044 OPEN REDUCTION CF FRACTURE				721.20*	721.20*	727.20*
045 ARTHROCENTESIS-MAJOR JOINT						
046 ARTHROTOMY	15.00*	21.40*	18.00	25.00	25.00	25.00
047 ARTHROPLASTY-REPAIR OF HIP				700.00	700.00	700.00
048 NEEDLE PUNCTURE OF BURSA				20.00	17.80*	21.00
049 BRONCHOSCOPY				128.30*	128.30*	107.00*
050 THORACENTESIS				30.00	30.00	35.70*

1979 PREVAILING CHARGE SUMMARY DATA UNION MUTUAL LIFE INSURANCE CO.

MAINE

PROCEDURE DESCRIP	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	AREA 01	AREA 02	AREA 03	AREA 01	AREA 02	AREA 03
CATHERIZATION OF HEART						
INSERTION OF PACEMAKER						
053 PARTIAL COLECTOMY				206.10*	206.10*	206.10*
054 APPENDECTOMY				600.00	600.00	600.00
055 SIGMOIDOSCOPY				640.00	713.00*	641.70*
056 HEMORRHOIDECTOMY				325.00	325.00	285.20*
057 CHOLECYSTECTOMY				22.70*	21.40*	25.00
058 REPAIR HERNIA				213.90*	245.00	213.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY				480.00	513.40*	477.70*
060 DILATION OF URETHRA				280.00	320.90*	280.00
061 PROSTATECTOMY				40.00	68.00	40.00
062 ELECTROSECTION-PROSTATE (TUR)				17.20*	17.20*	17.20*
063 HYSTERECTOMY				640.00	640.00	640.00
064 INITIAL COMPLETE EYE EXAM				680.00	680.00	680.00
065 COMPREHENSIVE EYE EXAM				540.00	540.00	540.00
066 EYE EXAM WITH TOMOMETRY				25.00	25.00	25.00
067 EXTRACTION OF LENS				20.00	20.00	20.00
068 CHEST X-RAY, SINGLE VIEW				10.00	10.00	10.00
069 CHEST X-RAY, TWO VIEWS				572.40*	572.40*	572.40*
070 X-RAY SPINE				15.00	15.00	15.00
071 X-RAY HIP				22.00*	22.00*	22.00*
072 X-RAY UPPER GI TRACT				35.00*	35.00*	35.00*
073 X-RAY COLON				25.00	25.00	25.00
074 RADIATION THERAPY-LOW VOLT				48.00*	48.00*	48.00*
075 RADIATION THERAPY-SUPER VOLT						
076 RADIATION THERAPY-NEGAVOLT						
077 CAT SCAN - HEAD						
078 CAT SCAN-HEAD, INTERPRET ONLY						
079 THREE CHEMISTRY TESTS						
080 TWELVE CHEMISTRY TESTS						
081 CULTURE-OTHER THAN BLOOD						
082 HEMOGLOBIN						
083 AUTOMATED BLOOD COUNT						
084 WHITE CELL COUNT						
085 COMPLETE BLOOD COUNT (CBC)						
086 CHOLESTEROL TEST						
087 FLOCCULATION TEST						
088 HEMATOCRIT						
089 PLATELET COUNT (REES-ECKER)						
090 POTASSIUM TEST						
091 PROTHROMBIN						
092 SEDIMENTATION RATE						
093 BLOOD SUGAR						
094 BUN-UREA, NITROGEN						
095 URIC ACID						
096 FECES-OCCULT BLOOD						
097 PAP TEST						
098 ROUTINE URINALYSIS						
099 CHEMICAL URINALYSIS						
100 PATHOLOGY-THREE SPECIMENS						

MARYLAND

MARYLAND



Three Localities: (Exclusive of Washington D.C. Locality.)

01 Baltimore City, Baltimore, Howard, Harford, Anne Arundel and Carroll Counties

02 Frederick, Washington, Allegany and Garrett Counties

03 Calvert, Charles, St. Mary's, Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Wicomico, Somerset and Worcester Counties

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	ZONE 1	ZONE 2	ZONE 3	ZONE 1	ZONE 2	ZONE 3
001 INITIAL BRIEF OFFICE VISIT	15.00			15.00	14.30*	14.30*
002 INITIAL LIMITED OFFICE VISIT		12.00	13.00	15.00	15.00	15.00
003 INIT INTERMED OFFICE VISIT				18.00	15.00	15.00
004 INIT COMP OFFICE VISIT	35.60*	45.00	18.00	57.10*	40.00	50.00
005 MINIMAL F/U OFFICE VISIT	10.00	2.00	5.00	5.00	5.00	5.00
006 BRIEF F/U OFFICE VISIT	10.00	10.00	10.00	15.00	14.30*	14.30*
007 LIMITED F/U OFFICE VISIT	15.00	12.00	13.00	18.00	15.00	15.00
008 INTERMED F/U OFFICE VISIT	15.00	12.00	12.00	18.00	15.00	15.00
009 EXTENDED F/U OFFICE VISIT	15.00	20.00	10.00	25.00	25.00	24.00
010 COMPLETE F/U OFFICE VISIT	35.60*	45.00	16.00	57.10*	40.00	50.00
011 BRIEF F/U HOME VISIT	14.30*	14.30*	14.30*	14.30*	15.00	12.00
012 LIMITED F/U HOME VISIT				20.00	15.00	17.10*
013 INTERMEDIATE F/U HOME VISIT	20.00	15.00	20.00	20.00	15.00	17.10*
014 EXTENDED CARE FACILITY VISIT				18.60*	14.30*	14.30*
015 BRIEF F/U NURSING HOME VISIT	10.00	10.00	10.00	15.00	12.00	14.30*
016 INITIAL BRIEF HOSPITAL VISIT	35.60*	35.60*	35.60*	71.30*	55.00	60.00
017 INIT INTERMED HOSPITAL VISIT				71.30*	55.00	60.00
018 INITIAL COMP HOSPITAL VISIT	35.60*	35.60*	35.60*	71.30*	55.00	60.00
019 BRIEF F/U HOSPITAL VISIT	14.30*	10.00	11.30*	14.30*	14.30*	14.30*
020 LIMITED F/U HOSPITAL VISIT	18.00	12.00	12.00	20.00	15.00	15.00
021 INTERMED F/U HOSPITAL VISIT	18.00	12.00	12.00	20.00	15.00	15.00
022 EXTENDED F/U HOSPITAL VISIT				30.00	20.00	25.00
023 BRIEF EMERGENCY ROOM VISIT				10.00	18.00	14.30*
024 LIMITED EMERGENCY ROOM VISIT				25.00	15.00	21.40*
025 INTERMED EMERGENCY ROOM VISIT				25.00	15.00	21.40*
026 LIMITED CONSULTATION	28.50*	28.50*	35.00	50.00	50.00	50.00
027 EXTENSIVE CONSULTATION				50.00	50.00	50.00
028 COMPREHENSIVE CONSULTATION				71.30*	60.00	60.00
029 PSYCHOTHERAPY-ONE HOUR				40.00	10.00	20.00
030 PSYCHOTHERAPY-HALF HOUR				40.00	10.00	20.00
031 CHIROPRACTIC OFFICE VISIT				10.00*	8.50	10.00
032 INITIAL PHYSIOTHERAPY				14.50*	10.00	21.00
033 F/U PODIATRIC OFFICE VISIT				10.00*	10.60*	12.40*
034 ELECTROCARDIOGRAM (ECG)	25.00	25.00	21.40*	25.00	25.00	21.40*
035 EKG-INTERPRET, REPORT ONLY	10.00	11.00	10.00	10.00	10.00	10.00
036 ARTERIAL BLOOD GAS STUDY				25.00	30.00	25.00
037 ELECTROENCEPHALOGRAPH (EEG)				70.00	70.00	
038 CHEMOTHERAPY					20.00	7.00
039 COLLECTION OF SPECIMENS				3.00	3.00	3.50
040 DEBRIDEMENT OF NAILS				20.10*	22.90*	39.10*
041 SKIN BIOPSY				30.00	30.00	20.00
042 CHEMOCAUTERY				20.00	20.00	15.00
043 RADICAL MASTECTOMY				713.20*	600.00	641.90*
044 OPEN REDUCTION OF FRACTURE				713.20*	713.20*	713.20*
045 ARTHROCENTESIS-MAJOR JOINT				35.00	28.50*	28.50*
046 ARTHROCENTESIS-MAJOR JOINT				35.00	28.50*	28.50*
047 ARTHROPLASTY-REPAIR OF HIP				784.50*	713.20*	713.20*
048 NEEDLE PUNCTURE OF BURSA				30.00	42.00	35.60*
049 BRONCHOSCOPY				142.60*	142.60*	142.60*
050 THORACENTESIS				71.30*	42.80*	50.00

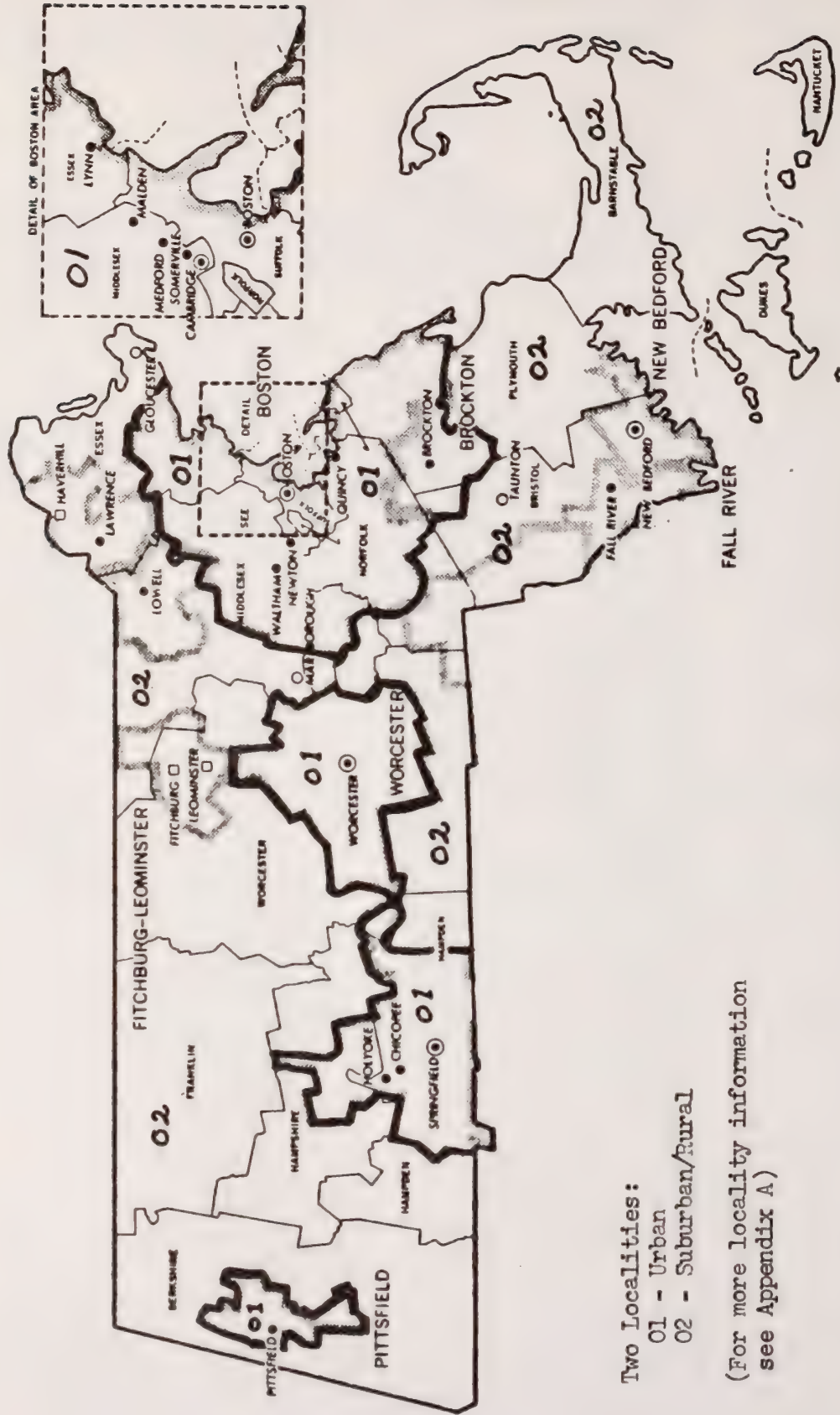
LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	ZONE 1	ZONE 2	ZONE 3	ZONE 1	ZONE 2	ZONE 3
051 CATHETERIZATION OF HEART				371.80*		362.90*
052 INSERTION OF PACEMAKER				855.80*	855.80*	855.80*
053 PARTIAL COLECTOMY				713.20*	575.00	713.20*
054 APPENDECTOMY				356.60*	285.30*	325.00
055 SIGMOIDOSCOPY				42.80*	30.00	28.50*
056 HEMORRHOIDECTOMY				285.30*	250.00	250.00
057 CHOLECYSTECTOMY				549.10*	427.90*	499.20*
058 REPAIR HERNIA				356.60*	285.30*	308.10*
059 DIAGNOSTIC CYSTOURETHROSCOPY				65.00	40.00	60.00
060 DILATION OF URETHRA				25.00	15.00	20.00
061 PROSTATECTOMY				784.50*	702.00	784.50*
062 ELECTROSECTION-PROSTATE (TUR)				713.20*	499.20*	713.20*
063 HYSTERECTOMY				713.20*	677.20*	641.90*
064 INITIAL COMPLETE EYE EXAM				20.00	15.00	16.00
065 COMPREHENSIVE EYE EXAM				35.00		22.00
066 EYE EXAM WITH TONOMETRY				5.00	10.00	7.00
067 EXTRACTION OF LENS				713.20*	570.60*	570.60*
068 CHEST X-RAY, SINGLE VIEW	17.10*	18.00	18.00	21.40*	21.40*	19.50*
069 CHEST X-RAY, TWO VIEWS	24.00	24.00	24.00	25.00	25.00	24.00
070 X-RAY SPINE				35.00	35.00	36.00
071 X-RAY HIP				28.50*	20.00	21.40*
072 X-RAY UPPER GI TRACT	45.00	24.50		62.00	45.00	62.00
073 X-RAY COLON				57.10*	60.00	60.00
074 RADIATION THERAPY-LOW VOLT				21.40*	15.00	15.00
075 RADIATION THERAPY-SUPER VOLT				21.40*	15.00	15.00
076 RADIATION THERAPY-MEGAVOLT				21.40*	15.00	15.00
077 CAT SCAN - HEAD				150.00	150.00	150.00
078 CAT SCAN-HEAD, INTERPRET ONLY				50.00	60.00	60.00
079 THREE CHEMISTRY TESTS				20.00	20.00	20.00
080 TWELVE CHEMISTRY TESTS				15.00	15.00	15.00
081 CULTURE-OTHER THAN BLOOD				3.00	4.00	3.00
082 HEMOGLOBIN						
083 AUTOMATED BLOOD COUNT				3.00	2.00	3.00
084 WHITE CELL COUNT				9.00	8.00	10.00
085 COMPLETE BLOOD COUNT (CBC)				5.00	6.00	6.00
086 CHOLESTEROL TEST				3.00	3.00	3.00
087 FLOCCULATION TEST				3.00	3.00	3.00
088 HEMATOCRIT				3.00	3.00	3.00
089 PLATELET COUNT (REES-ECKER)				5.00	4.00	4.00
090 POTASSIUM TEST				6.00	6.00	6.00
091 PROTHROMBIN				5.00	4.00	7.00
092 SEDIMENTATION RATE				3.50	4.00	5.00
093 BLOOD SUGAR				5.00	5.50	5.00
094 UREA-NITROGEN				5.00	6.00	6.00
095 URIC ACID				5.00	6.00	6.00
096 FECES-OCULT BLOOD				4.00	3.00	2.50
097 PAP TEST				7.00	7.00	6.00
098 ROUTINE URINALYSIS				5.00	3.00	4.00
099 CHEMICAL URINALYSIS				3.00	3.00	2.00
100 PATHOLOGY-THREE SPECIMENS				15.00	20.00	15.00

MASSACHUSETTS

MASSACHUSETTS



PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	URBAN	SUBURB	URBAN	SUBURB
001 INITIAL BRIEF OFFICE VISIT				
002 INITIAL LIMITED OFFICE VISIT				
003 INIT INTERMED OFFICE VISIT				
004 INIT COMP OFFICE VISIT				
005 MINIMAL F/U OFFICE VISIT	28.50*	15.00	35.70*	35.70*
006 BRIEF F/U OFFICE VISIT	11.40*	11.40*	16.00	14.30*
007 LIMITED F/U OFFICE VISIT				
008 INTERMED F/U OFFICE VISIT	20.00	15.00	28.00	20.00
009 EXTENDED F/U OFFICE VISIT				
010 COMPLETE F/U OFFICE VISIT				
011 BRIEF F/U HOME VISIT	17.10*	14.30*	15.00*	17.10*
012 LIMITED F/U HOME VISIT				
013 INTERMDIATE F/U HOME VISIT				
014 EXTENDED CARE FACILITY VISIT				
015 BRIEF F/U NURSING HOME VISIT				
016 INITIAL BRIEF HOSPITAL VISIT				
017 INIT INTERMED HOSPITAL VISIT				
018 INITIAL COMP HOSPITAL VISIT				
019 BRIEF F/U HOSPITAL VISIT	21.40*	21.40*	35.70*	35.70*
020 LIMITED F/U HOSPITAL VISIT	14.30*	14.30*	18.50*	14.30*
021 INTERMED F/U HOSPITAL VISIT	15.00	19.10*	24.70*	20.00
022 EXTENDED F/U HOSPITAL VISIT				
023 BRIEF EMERGENCY ROOM VISIT				
024 LIMITED EMERGENCY ROOM VISIT				
025 INTERMED EMERGENCY ROOM VISIT				
026 LIMITED CONSULTATION				
027 EXTENSIVE CONSULTATION				
028 COMPREHENSIVE CONSULTATION			57.00*	49.90*
029 PSYCHOTHERAPY-ONE HOUR			43.20*	30.20*
030 PSYCHOTHERAPY-HALF HOUR			30.20*	20.00
031 CHIROPRACTIC OFFICE VISIT			11.30*	10.00
032 INITIAL PHYSIOTHERAPY			15.00	17.00
033 F/U PODIATRIC OFFICE VISIT			11.40*	11.40*
034 ELECTROCARDIOGRAM (EKG)			21.80	21.80
035 EKG-INTERPRET.REPORT ONLY		25.00	12.90	12.90
036 ARTERIAL BLOOD GAS STUDY	21.40*	15.00	62.00	50.00
037 ELECTROENCEPHALOGRAPH (EEG)	20.00		6.50	15.00*
038 CHEMOTHERAPY				
039 COLLECTION OF SPECIMENS				
040 DEBRIDEMENT OF NAILS				
041 SKIN BIOPSY			35.00	25.00
042 CHEMOCAUTERY			35.00	30.00
043 RADICAL MASTECTOMY			713.00*	630.00
044 OPEN REDUCTION OF FRACTURE			713.00*	713.00*
045 ARTHROCENTESIS-MAJOR JOINT			35.00	35.00
046 ARTHROTOMY			35.00*	35.00
047 ARTHROPLASTY-REPAIR OF HIP		20.00	1160.00	713.00*
048 NEEDLE PUNCTURE OF BURSA			35.00	35.00
049 BRONCHOSCOPY			142.60*	175.00
050 THORACENTESIS	28.60		49.90*	49.90*

1979 PREVAILING CHARGE SUMMARY DATA B/S OF MASSACHUSETTS

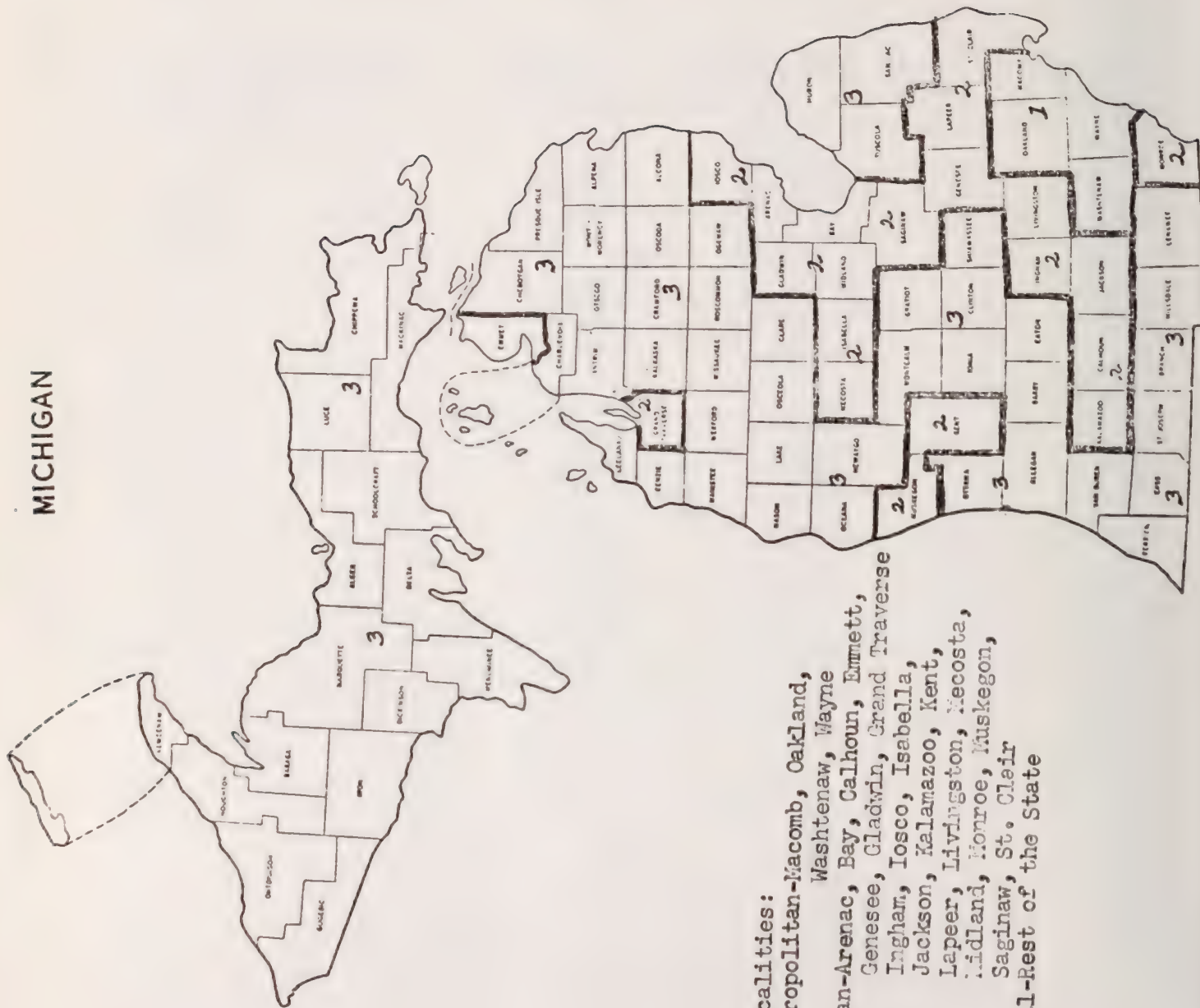
MASSACHUSETTS

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	URBAN	SUBURB	URBAN	SUBURB
051 CATHETERIZATION OF HEART			50.00	50.00
052 INSERTION OF PACEMAKER			855.60*	1250.00
053 PARTIAL COLECTOMY			850.00	713.00*
054 TOTAL COLECTOMY			356.50*	355.50*
055 SIGMOIDOSCOPY			35.70*	35.00
056 HEMORRHOIDECTOMY		25.00	285.20*	285.20*
057 SPHEROCECTOMY			598.90*	534.75*
058 REPAIR HERNIA			356.50*	320.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY		62.50	75.00	73.90*
060 DILATION OF URETHRA			25.00	20.00
061 SPOLIATICTOMY			760.00	641.70*
062 ELECTROSECTION-PROSTATE (TUR)	603.20	601.60	713.00*	570.40*
063 HYSTERECTOMY			713.00*	570.40*
064 INITIAL COMPLETE EYE EXAM			21.40*	21.40*
065 COMPREHENSIVE EYE EXAM				
066 EYE EXAM WITH TONOMETRY				
067 EXTRACTION OF LENS	850.00	750.00	713.00*	713.00
068 CHEST X-RAY, SINGLE VIEW	21.40*	20.00	21.40*	23.00
069 CHEST X-RAY, TWO VIEWS	28.50*	21.40*	26.00	26.00
070 X-RAY SPINE			28.50*	30.00
071 X-RAY HIP			25.00	27.00
072 X-RAY UPPER GI TRACT	45.00	32.50*	57.00*	53.00
073 X-RAY COLON	27.00	31.00	51.30*	49.90*
074 RADIATION THERAPY-LOW VOLT			27.00	29.90*
075 RADIATION THERAPY-SUPER VOLT				
076 RADIATION THERAPY-MEDAVOLT				
077 CAT SCAN - HEAD				
078 CAT SCAN-HEAD, INTERPRET ONLY			262.20*	270.00
079 THREE CHEMISTRY TESTS			67.60*	246.00
080 TWELVE CHEMISTRY TESTS			3.00	3.00
081 CULTURE-OTHER THAN BLOOD			12.00	12.00
082 HEMOGLOBIN			8.00	8.00
083 AUTOMATED BLOOD COUNT			3.50	3.50
084 WHITE CELL COUNT			10.00	10.00
085 COMPLETE BLOOD COUNT (CBC)			4.00	4.00
086 CHOLESTEROL TEST			9.00	9.00
087 FLOCCULATION TEST			7.00	7.00
088 HEMATOCRIT				
089 PLATELET COUNT (REES-ECKER)			4.00	4.00
090 POTASSIUM TEST			7.00	7.00
091 PROTHROMBIN			7.00	7.00
092 SEDIMENTATION RATE			5.00	5.00
093 BLOOD SUGAR			6.00	6.00
094 SERUM CREA. NITROGEN			6.50	6.50
095 URIC ACID			7.00	7.00
096 FECES-OCCULT BLOOD			5.00	5.00
097 PAP TEST			10.00	10.00
098 ROUTINE URINALYSIS			5.00	5.00
099 CHEMICAL URINALYSIS			5.00	5.00
100 PATHOLOGY-THREE SPECIMENS			25.00	25.00

MICHIGAN

MICHIGAN



Three Localities:

- 1 - Metropolitan-Macomb, Oakland, Washtenaw, Wayne
Genesee, Gladwin, Grand Traverse
Ingham, Iosco, Isabella,
Jackson, Kalamazoo, Kent,
Lapeer, Livingston, Mecosta,
Midland, Monroe, Muskegon,
Saginaw, St. Clair
- 2 - Urban-Arenac, Bay, Calhoun, Emmett,
Genesee, Gladwin, Grand Traverse
Ingham, Iosco, Isabella,
Jackson, Kalamazoo, Kent,
Lapeer, Livingston, Mecosta,
Midland, Monroe, Muskegon,
Saginaw, St. Clair
- 3 - Rural-Rest of the State

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	1	2	3	1	2	3	
001 INITIAL BRIEF OFFICE VISIT	14.30*		18.50*	28.50*	25.00	21.40*	001
002 INITIAL LIMITED OFFICE VISIT		15.00		28.50*	25.00	21.40*	002
003 INIT INTERMED OFFICE VISIT	15.00			28.50*	25.00	21.40*	003
004 INIT COMP OFFICE VISIT	8.60*	25.00	35.00	48.00	45.00	30.00	004
005 MINIMAL F/U OFFICE VISIT	8.60*	10.00*	11.40*	10.00	11.40*	10.00	005
006 BRIEF F/U OFFICE VISIT	8.60*	10.00*	11.40*	10.00	11.40*	10.00	006
007 LIMITED F/U OFFICE VISIT	8.60*	10.00*	11.40*	10.00	11.40*	10.00	007
008 INTERMED F/U OFFICE VISIT	14.30*	15.00	18.50*	28.50*	25.00	21.40*	008
009 EXTENDED F/U OFFICE VISIT	15.00	25.00	35.00	48.00	45.00	30.00*	009
010 COMPLETE F/U OFFICE VISIT	14.30*	14.30*	21.40*	21.40*	17.10*	14.30*	010
011 BRIEF F/U HOME VISIT				21.40*	17.10*	14.30*	011
012 LIMITED F/U HOME VISIT	14.30*	14.30*	21.40*	21.40*	17.10*	14.30*	012
013 INTERMEDIATE F/U HOME VISIT				21.40*	17.10*	14.30*	013
014 EXTENDED CARE FACILITY VISIT	6.25*	7.50*	6.90*	7.20*	6.80*	5.70*	014
015 BRIEF F/U NURSING HOME VISIT	35.70*	35.70*	35.70*	50.00*	50.00*	49.90*	015
016 INITIAL BRIEF HOSPITAL VISIT				50.00*	50.00*	49.90*	016
017 INIT INTERMED HOSPITAL VISIT	35.70*	35.70*	35.70*	50.00*	50.00*	49.90*	017
018 INITIAL COMP HOSPITAL VISIT	11.25*	13.10*	13.80*	16.00*	13.80*	13.30*	018
019 BRIEF F/U HOSPITAL VISIT	11.25*	13.10*	13.80*	16.00*	13.80*	13.30*	019
020 LIMITED F/U HOSPITAL VISIT	11.25*	13.10*	13.80*	16.00*	13.80*	13.30*	020
021 INTERMED F/U HOSPITAL VISIT				16.00*	13.60*	13.30*	021
022 EXTENDED F/U HOSPITAL VISIT				16.00*	13.60*	13.30*	022
023 BRIEF EMERGENCY ROOM VISIT				15.00	15.00	15.00	023
024 LIMITED EMERGENCY ROOM VISIT				15.00	15.00	15.00	024
025 INTERMED EMERGENCY ROOM VISIT				15.00	15.00	15.00	025
026 LIMITED CONSULTATION	28.50*	35.70*	35.70*	49.90*	42.80*	42.80*	026
027 EXTENSIVE CONSULTATION				49.90*			027
028 COMPREHENSIVE CONSULTATION				64.20*	57.00	57.00*	028
029 PSYCHOTHERAPY-ONE HOUR				49.00	49.00	45.00*	029
030 PSYCHOTHERAPY-HALF HOUR				28.50*	27.50	26.50*	030
031 CHIROPRACTIC OFFICE VISIT	8.20*	10.00*	11.40*	11.40*	10.00	8.20*	031
032 INITIAL PHYSIOTHERAPY							032
033 F/U PODIATRIC OFFICE VISIT				10.00	11.40*	10.00	033
034 ELECTROCARDIOGRAM (ECG)	21.40*	21.40*	21.40*	21.40*	21.40*	21.40*	034
035 EKG-INTERPRET.REPORT ONLY	14.00*	14.00*	14.00*	14.00	14.00	14.00	035
036 ARTERIAL BLOOD GAS STUDY							036
037 ELECTROENCEPHALOGRAM (EEG)							037
038 CHEMOTHERAPY				49.90*	49.90*	35.00	038
039 COLLECTION OF SPECIMENS				2.00	2.00	2.00	039
040 DEBRIDEMENT OF NAILS				3.00	3.00	3.00	040
041 SKIN BIOPSY				21.40*	20.00	21.40*	041
042 CHEMOCAUTERY				35.00	35.00*	25.00	042
043 RADICAL MASTECTOMY				21.40*	21.40*	21.40*	043
044 OPEN REDUCTION OF FRACTURE				713.00*	627.40*	570.40*	044
045 ARTHROCENTESIS-MAJOR JOINT				570.40*	570.40*	500.00*	045
046 ARTHROTOMY				35.70*	32.10*	28.50*	046
047 ARTHROPLASTY-REPAIR OF HIP	25.00	35.00	35.70*	35.70*	32.10*	28.50*	047
048 NEEDLE PUNCTURE OF BURSA				1426.00*	1500.00	1426.00*	048
049 BRONCHOSCOPY				178.25*	149.70*	142.60*	049
050 THORACENTESIS				42.80*	35.70*	25.70*	050

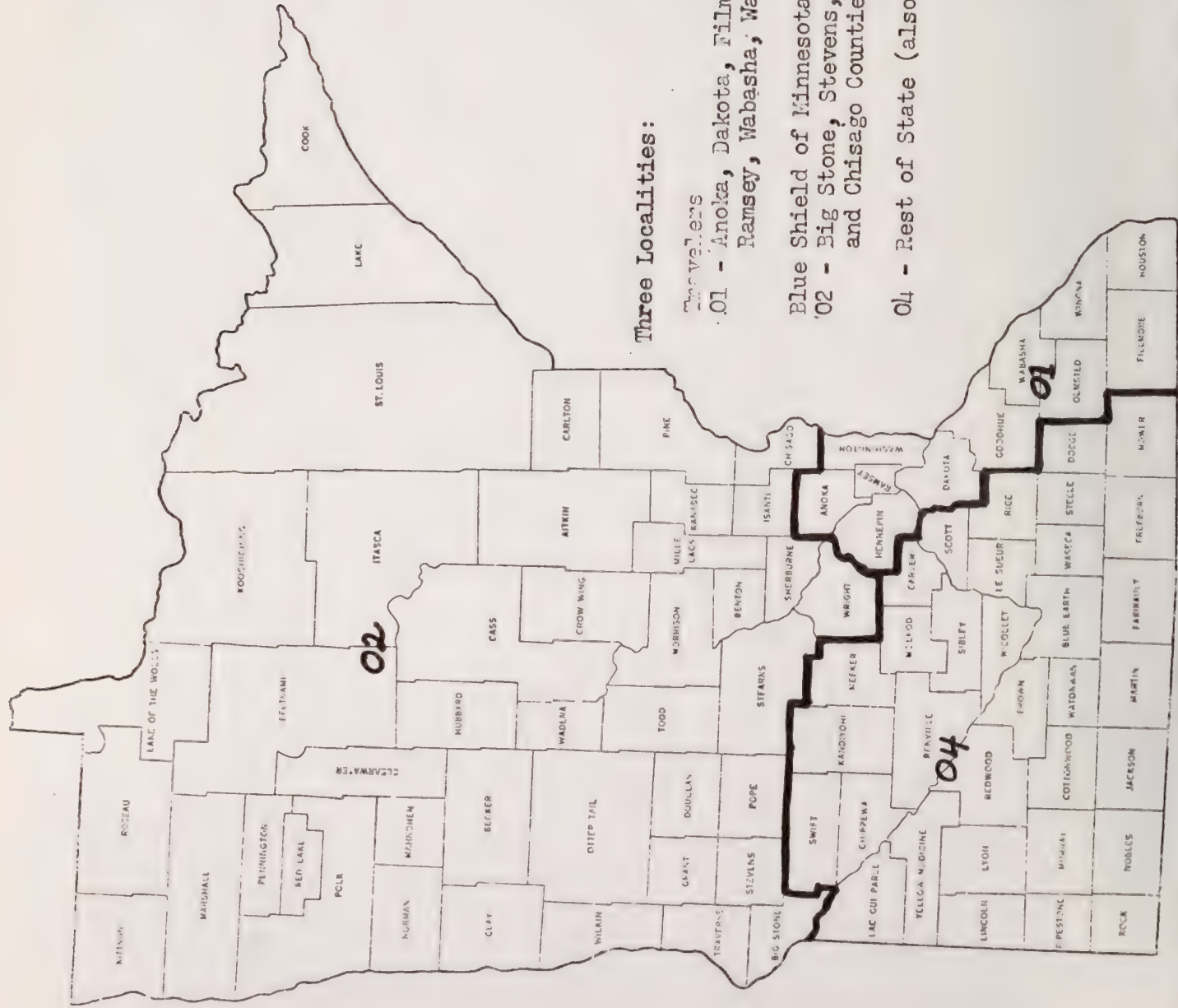
1979 PREVAILING CHARGE SUMMARY DATA B/C-B/S OF MICHIGAN

MICHIGAN

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	1	2	3	1	2	3
051 CATHETERIZATION OF HEART				499.10*	450.00*	541.00*
052 INSERTION OF PACEMAKER				900.00	900.00*	700.00*
053 PARTIAL COLECTOMY				677.20*	641.70*	598.90*
054 APPENDECTOMY				374.30*	320.80*	285.20*
055 Sigmoidoscopy	28.00	32.10*	28.50*	38.00	28.50*	28.50*
056 HEMORRHOIDECTOMY				356.50*	308.00*	285.20*
057 CHOLECYSTECTOMY				570.40*	509.80*	470.60*
058 REPAIR HERNIA				356.50*	285.20*	256.70*
059 DIAGNOSTIC CYSTOURETHROSCOPY	71.30*	85.60*	71.30*	95.00	66.00	70.40
060 CATHETERIZATION OF URETHRA				21.40*	20.00	21.40*
061 PROSTATECTOMY				713.00*	641.70*	641.70*
062 ELECTROSECTION-PROSTATE (TUR)	534.70*	588.00	619.70	684.50*	641.70*	641.70*
063 HYSTERECTOMY				741.50*	598.90*	534.70*
064 INITIAL COMPLETE EYE EXAM				28.50*	25.00	21.40*
065 COMPREHENSIVE EYE EXAM				23.50	20.00	16.40*
066 EYE EXAM WITH TONOMETRY				10.00	11.40*	10.00*
067 EXTRACTION OF LENS				713.00*	606.00*	570.40*
068 CHEST X-RAY, SINGLE VIEW	570.40*	606.00*	713.00*	14.30*	10.00	14.30*
069 CHEST X-RAY, TWO VIEWS	20.00	24.00	23.50*	21.40*	20.00	19.00
070 X-RAY SPINE				35.00	34.50	28.50*
071 X-RAY HIP				23.50*	25.00	20.00
072 X-RAY UPPER GI TRACT	49.90	50.00	49.90*	49.90*	45.00	40.00
073 X-RAY COLON				50.00	48.00	42.80
074 RADIATION THERAPY-LOW VOLT	22.50	22.50	25.00	25.00	22.50	22.50
075 RADIATION THERAPY-SUPER VOLT	30.00	30.00	33.00	33.00	30.00	30.00
076 RADIATION THERAPY-MEGAVOLT				33.00	30.00	30.00
077 CAT SCAN - HEAD				164.00	164.00	164.00
078 CAT SCAN-HEAD, INTERPRET ONLY						
079 THREE CHEMISTRY TESTS				3.00	3.00	3.00
080 TWELVE CHEMISTRY TESTS				12.00	12.00	12.00
081 CULTURE-OTHER THAN BLOOD				10.00	10.00	10.00
082 HEMOGLOBIN				3.00	3.00	3.00
083 AUTOMATED BLOOD COUNT				4.00	4.00	4.00
084 WHITE CELL COUNT				3.00	3.00	3.00
085 COMPLETE BLOOD COUNT (CBC)				6.00	6.00	6.00
086 CHOLESTEROL TEST				5.00	5.00	5.00
087 FLOCCULATION TEST				3.00	3.00	3.00
088 HEVATOCRIT				3.00	3.00	3.00
089 PLATELET COUNT (REES-ECKER)				3.00	3.00	3.00
090 POTASSIUM TEST				5.00	5.00	5.00
091 PROTHROMBIN				5.00	5.00	5.00
092 SEDIMENTATION RATE				3.00	3.00	3.00
093 BLOOD SUGAR				4.00	4.00	4.00
094 BUN-UREA-NITROGEN				4.00	4.00	4.00
095 URIC ACID				9.00	5.00	5.00
096 FECES-OCULT BLOOD				1.00	1.00	1.00
097 PAP TEST				5.00	5.00	5.00
098 ROUTINE URINALYSIS				3.00	3.00	3.00
099 CHEMICAL URINALYSIS				1.50	1.50	1.50
100 PATHOLOGY-THREE SPECIMENS				15.00	15.00	15.00

MINNESOTA

MINNESOTA



Three Localities:

Travelers

01 - Anoka, Dakota, Fillmore, Goodhue, Hennepin, Houston, Olmstead, Ramsey, Wabasha, Washington, and Winona Counties

Blue Shield of Minnesota

02 - Big Stone, Stevens, Pope, Stearns, Wright, Sherburne, Isanti, and Chisago Counties and all points North

04 - Rest of State (also excluding Travelers' localities)

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	AREA 1		AREA 1	
001 INITIAL BRIEF OFFICE VISIT			11.30*	001
002 INITIAL LIMITED OFFICE VISIT	14.30*		20.00*	002
003 INIT INTERMED OFFICE VISIT			28.50*	003
004 INIT COMP OFFICE VISIT	35.00		57.00*	004
005 MINIMAL F/U OFFICE VISIT	10.00*		11.30*	005
006 BRIEF F/U OFFICE VISIT	10.00*		11.30*	006
007 LIMITED F/U OFFICE VISIT	10.00*		11.30*	007
008 INTERMED F/U OFFICE VISIT	14.30*		20.00*	008
009 EXTENDED F/U OFFICE VISIT	20.00		28.50*	009
010 COMPLETE F/U OFFICE VISIT	35.00		57.00*	010
011 BRIEF F/U HOME VISIT	16.00		21.30*	011
012 LIMITED F/U HOME VISIT			25.70*	012
013 INTERMEDIATE F/U HOME VISIT	20.00		35.00	013
014 EXTENDED CARE FACILITY VISIT			14.30*	014
015 BRIEF F/U NURSING HOME VISIT	10.00		11.30	015
016 INITIAL BRIEF HOSPITAL VISIT	16.50		25.00	016
017 INIT INTERMED HOSPITAL VISIT			35.60*	017
018 INITIAL COMP HOSPITAL VISIT	35.60*		57.00*	018
019 BRIEF F/U HOSPITAL VISIT	10.00*		14.30*	019
020 LIMITED F/U HOSPITAL VISIT	10.00*		14.30*	020
021 INTERMED F/U HOSPITAL VISIT	16.50		25.00	021
022 EXTENDED F/U HOSPITAL VISIT			35.60*	022
023 BRIEF EMERGENCY ROOM VISIT			14.30*	023
024 LIMITED EMERGENCY ROOM VISIT			21.00	024
025 INTERMED EMERGENCY ROOM VISIT			28.50*	025
026 LIMITED CONSULTATION	14.30*		24.00*	026
027 EXTENSIVE CONSULTATION			49.90*	027
028 COMPREHENSIVE CONSULTATION			57.00*	028
029 PSYCHOTHERAPY-ONE HOUR			53.00	029
030 PSYCHOTHERAPY-HALF HOUR			30.00	030
031 CHIROPRACTIC OFFICE VISIT	10.00*		10.50	031
032 INITIAL PHYSIOTHERAPY			16.60*	032
033 F/U PODIATRIC OFFICE VISIT			10.00*	033
034 ELECTROCARDIOGRAM (EKG)	20.00		20.00	034
035 EKG-INTERPRET, REPORT ONLY	7.50		7.50	035
036 ARTERIAL BLOOD GAS STUDY			22.80	036
037 ELECTROENCEPHALOGRAPH (EEG)			57.00*	037
038 CHEMOTHERAPY				038
039 COLLECTION OF SPECIMENS			6.80*	039
040 DEBRIDEMENT OF NAILS			8.00	040
041 SKIN BIOPSY			32.00	041
042 CHEMOCAUTERY			15.00	042
043 RADICAL MASTECTOMY			641.70*	043
044 OPEN REDUCTION OF FRACTURE			713.00*	044
045 ARTHROCENTESIS-MAJOR JOINT			10.00	045
046 ARTHROTOMY			19.75	046
047 ARTHROPLASTY-REPAIR OF HIP	15.00		800.00	047
048 NEEDLE PUNCTURE OF BURSA			19.75	048
049 BRONCHOSCOPY			171.10*	049
050 THORACENTESIS			35.60*	050

1979 PREVAILING CHARGE SUMMARY DATA

THE TRAVELERS INSURANCE COMPANY

MINNESOTA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	AREA 1	AREA 1
051 CATHETERIZATION OF HEART		427.80*
052 INSERTION OF PACEMAKER		818.30*
053 PARTIAL COLECTOMY		784.30*
054 APPENDECTOMY		350.00
055 SIGMOIDOSCOPY	21.30*	28.50*
056 HEMORRHOIDECTOMY		328.00*
057 CHOLECYSTECTOMY		513.40*
058 REPAIR HERNIA		356.50*
059 DIAGNOSTIC CYSTOURETHROSCOPY	42.80*	42.80*
060 DILATION OF URETHRA		14.00
061 PROSTATECTOMY		684.50*
062 ELECTROSECTION-PROSTATE (TUR)	725.00	641.70*
063 HYSTRECTOMY		641.70*
064 INITIAL COMPLETE EYE EXAM		25.60
065 COMPREHENSIVE EYE EXAM		25.60
066 EYE EXAM WITH TONOMETRY		14.30*
067 EXTRACTION OF LENS	650.00	641.70*
068 CHEST X-RAY, SINGLE VIEW	17.00	15.70*
069 CHEST X-RAY, TWO VIEWS	21.30*	21.30*
070 X-RAY SPINE		35.60*
071 X-RAY HIP		28.50*
072 X-RAY UPPER GI TRACT	45.60*	42.80*
073 X-RAY COLON		42.80*
074 RADIATION THERAPY-LOW VOLT		18.00
075 RADIATION THERAPY-SUPER VOLT	13.40	16.00*
076 RADIATION THERAPY-MEGAVOLT	13.40	11.00*
077 CAT SCAN - HEAD		240.00
078 CAT SCAN-HEAD, INTERPRET ONLY		50.00
079 THREE CHEMISTRY TESTS		15.00
080 TWELVE CHEMISTRY TESTS		20.00
081 CULTURE-OTHER THAN BLOOD		10.00
082 HEMOGLOBIN		4.00
083 AUTOMATED BLOOD COUNT		13.00
084 WHITE CELL COUNT		4.30
085 COMPLETE BLOOD COUNT (CBC)		13.00
086 CHOLESTEROL TEST		8.00
087 FLOCCULATION TEST		5.00
088 HEMATOCRIT		4.50
089 PLATELET COUNT (REES-ECKER)		7.50
090 POTASSIUM TEST		8.00
091 PROTHROMBIN		6.30
092 SEDIMENTATION RATE		5.00
093 BLOOD SUGAR		7.75
094 SUN-UREA, NITROGEN		8.40
095 URIC ACID		8.40
096 FECES-OCCULT BLOOD		3.60
097 PAP TEST		11.00
098 ROUTINE URINALYSIS		5.50
099 CHEMICAL URINALYSIS		3.30
100 PATHOLOGY-THREE SPECIMENS		20.00

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	04	02	04	02
001 INITIAL BRIEF OFFICE VISIT			13.50	13.50
002 INITIAL LIMITED OFFICE VISIT	21.70*	19.30*	28.10*	22.10*
003 INIT INTERMED OFFICE VISIT			13.50	13.50
004 INIT COMP OFFICE VISIT	38.50*	42.80*	55.00	42.80*
005 MINIMAL F/U OFFICE VISIT	6.00	6.00	6.00	9.00
006 BRIEF F/U OFFICE VISIT	8.60*	8.60*	8.60*	10.00*
007 LIMITED F/U OFFICE VISIT	8.60*	8.60*	8.60*	10.00*
008 INTERMED F/U OFFICE VISIT	10.00	10.60*	13.50	13.50
009 EXTENDED F/U OFFICE VISIT	15.00	15.50	20.00	20.00
010 COMPLETE F/U OFFICE VISIT	21.70*	19.30*	28.10*	22.10*
011 BRIEF F/U HOME VISIT	15.00	15.00	16.00	13.00
012 LIMITED F/U HOME VISIT			16.00	13.00
013 INTERMEDIATE F/U HOME VISIT	15.00	15.00	16.00	13.00
014 EXTENDED CARE FACILITY VISIT			8.60*	10.00*
015 BRIEF F/U NURSING HOME VISIT	8.60*	8.60*	8.60*	10.00*
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	21.40*	25.00	30.00
017 INIT INTERMED HOSPITAL VISIT			35.00*	42.80*
018 INITIAL COMP HOSPITAL VISIT	40.00	42.80*	52.50	50.00
019 BRIEF F/U HOSPITAL VISIT	8.60*	7.10*	10.00*	10.00*
020 LIMITED F/U HOSPITAL VISIT	8.60*	7.10*	10.00*	10.00*
021 INTERMED F/U HOSPITAL VISIT	15.00	15.00	15.00	21.40*
022 EXTENDED F/U HOSPITAL VISIT			18.80	25.00
023 BRIEF EMERGENCY ROOM VISIT				
024 LIMITED EMERGENCY ROOM VISIT				
025 INTERMED EMERGENCY ROOM VISIT				
026 LIMITED CONSULTATION	25.00	22.50	29.00	30.00
027 EXTENSIVE CONSULTATION			50.00	49.90*
028 COMPREHENSIVE CONSULTATION			55.00	52.50
029 PSYCHOTHERAPY-ONE HOUR			60.00	60.00
030 PSYCHOTHERAPY-HALF HOUR			30.00	30.00
031 CHIROPRACTIC OFFICE VISIT	8.60*	8.60*	8.60*	8.60*
032 INITIAL PHYSIOTHERAPY			8.60*	10.00
033 F/U PODIATRIC OFFICE VISIT			10.00*	10.00*
034 EKG-INTERPRET (EKG)	20.00	21.20	20.00	21.20
035 EKG-INTERPRET-REPORT ONLY	10.00	10.50	10.00	10.50
036 ARTERIAL BLOOD GAS STUDY			15.00	15.00
037 ELECTROENCEPHALOGRAPH (EEG)			50.00	54.00
038 CHEMOTHERAPY				
039 COLLECTION OF SPECIMENS			3.00	3.00
040 DEBRIDEMENT OF NAILS			15.00	17.00
041 SKIN BIOPSY			25.00	25.00
042 CHEMOCAUTERY			14.50	16.50
043 RADICAL MASTECTOMY			499.10*	499.10*
044 OPEN REDUCTION OF FRACTURE			684.50*	640.00
045 ARTHROCENTESIS-MAJOR JOINT			21.60	20.00
046 ARTHROTOMY			14.30*	14.30*
047 ARTHROPLASTY-REPAIR OF HIP	15.00	15.00	941.20*	840.00
048 NEEDLE PUNCTURE OF BURSA			20.00	15.00*
049 BRONCHOSCOPY			135.50*	142.60*
050 THORACENTESIS			25.00	25.00

1979 PREVAILING CHARGE SUMMARY DATA B/C-B/S OF MINNESOTA

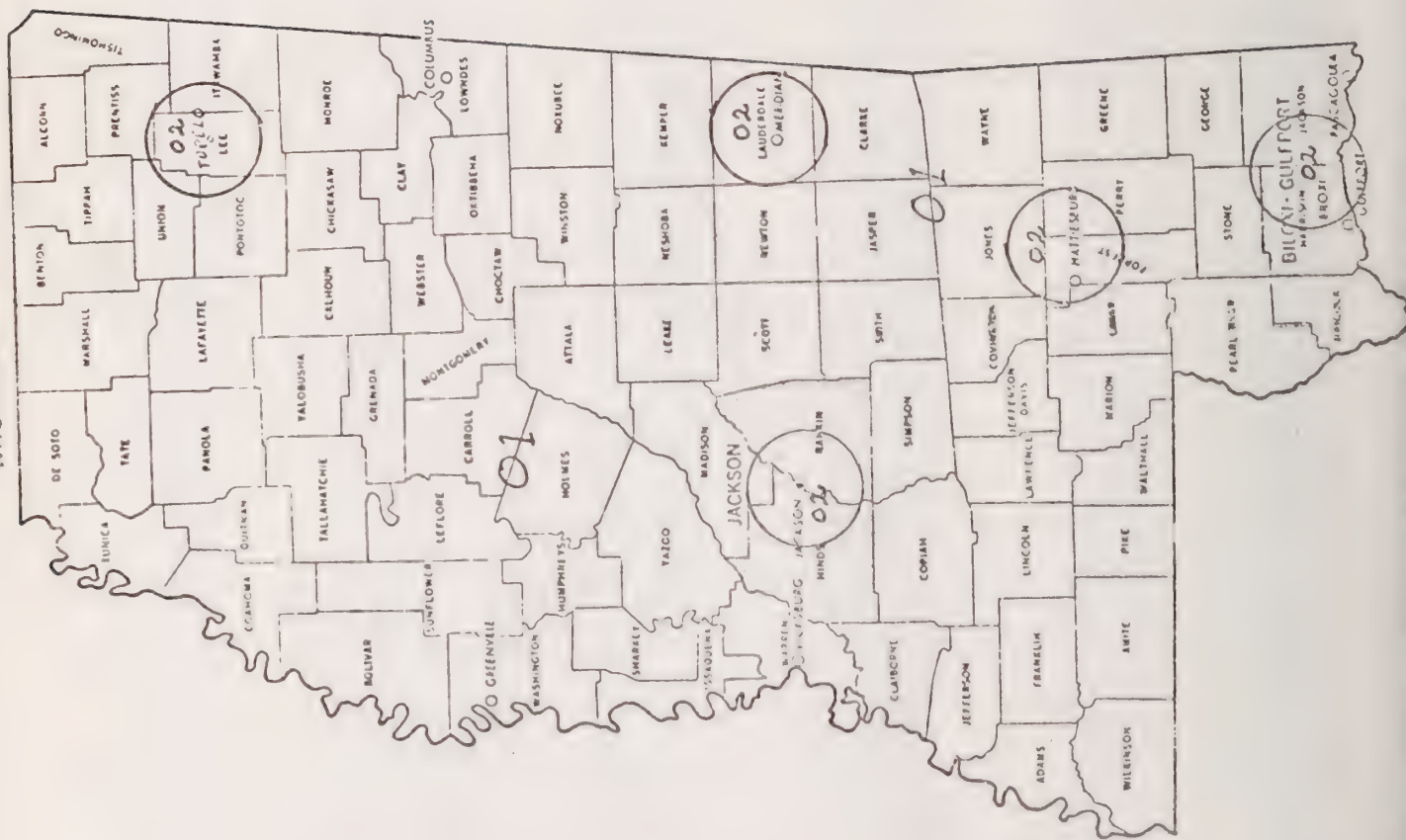
MINNESOTA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	04	02	04	02
051 CATHETERIZATION OF HEART			336.00	413.00
052 INSERTION OF PACEMAKER			840.00	900.00
053 PARTIAL COLECTOMY			570.40*	684.50*
054 APPENDECTOMY			335.00	320.00
055 SIGMOIDOSCOPY	21.40*	21.40*	20.00	25.70*
056 HEMORRHOIDECTOMY			252.00	269.50*
057 CHOLECYSTECTOMY			450.00	513.40*
058 REPAIR HERNIA			298.00	320.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY			40.00	40.00
060 DILATION OF URETHRA	40.00	42.00	16.50*	16.50*
061 PROSTATECTOMY			684.50*	684.50*
062 ELECTROSECTION-PROSTATE (TUR)	700.00	718.70*	684.50*	780.00
063 HYSTERECTOMY			623.90*	594.00
064 INITIAL COMPLETE EYE EXAM			24.00	24.00
065 COMPREHENSIVE EYE EXAM			24.00	24.00
066 EYE EXAM WITH TONOMETRY			10.00	10.00
067 EXTRACTION OF LENS	570.40*	570.40*	570.40*	570.40*
068 CHEST X-RAY, SINGLE VIEW	15.00	15.00	5.70*	5.70*
069 CHEST X-RAY, TWO VIEWS	20.00	22.50	8.60*	8.60*
070 X-RAY SPINE			10.00	10.00
071 X-RAY HIP			9.00	9.00
072 X-RAY UPPER GI TRACT	49.00	42.80*	22.00	22.00
073 X-RAY COLON			18.50	18.50
074 RADIATION THERAPY-LOW VOLT	15.00	15.00	15.00	15.00
075 RADIATION THERAPY-SUPER VOLT	15.00	15.00	15.00	15.00
076 RADIATION THERAPY-MEGAVOLT			15.00	15.00
077 CAT SCAN - HEAD			15.00	15.00
078 CAT SCAN-HEAD, INTERPRET ONLY			50.00	50.00
079 THREE CHEMISTRY TESTS			50.00	50.00
080 TWELVE CHEMISTRY TESTS			7.00	7.00
081 CULTURE-OTHER THAN BLOOD			12.00	12.00
082 HEMOGLOBIN			8.00	8.00
083 AUTOMATED BLOOD COUNT			3.60	3.60
084 WHITE CELL COUNT			7.75	7.75
085 COMPLETE BLOOD COUNT (CBC)			4.00	4.00
086 CHOLESTEROL TEST			5.50	5.50
087 FLOCCULATION TEST			4.60	4.60
088 HENATOCRT			4.70	4.70
089 PLATELET COUNT (REES-ECKER)			4.00	4.00
090 POTASSIUM TEST			5.00	5.00
091 PROTHROMBIN			4.00	4.00
092 SEDIMENTATION RATE			5.60	5.60
093 BLOOD SUGAR			5.00	5.00
094 BUN-UREA, NITROGEN			4.00	4.00
095 URIC ACID			3.30	3.30
096 FECES-OCCULT BLOOD			4.00	4.00
097 PAP TEST			4.50	4.50
098 ROUTINE URINALYSIS			5.00	5.00
099 CHEMICAL URINALYSIS			3.00	3.00
100 PATHOLOGY-THREE SPECIMENS			20.00	20.00

MISSISSIPPI

Mississippi



Two Localities:
 01 - Rural
 02 - Metropolitan

(For more locality information
 see Appendix A)

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

AREA 1

AREA 2

AREA 1

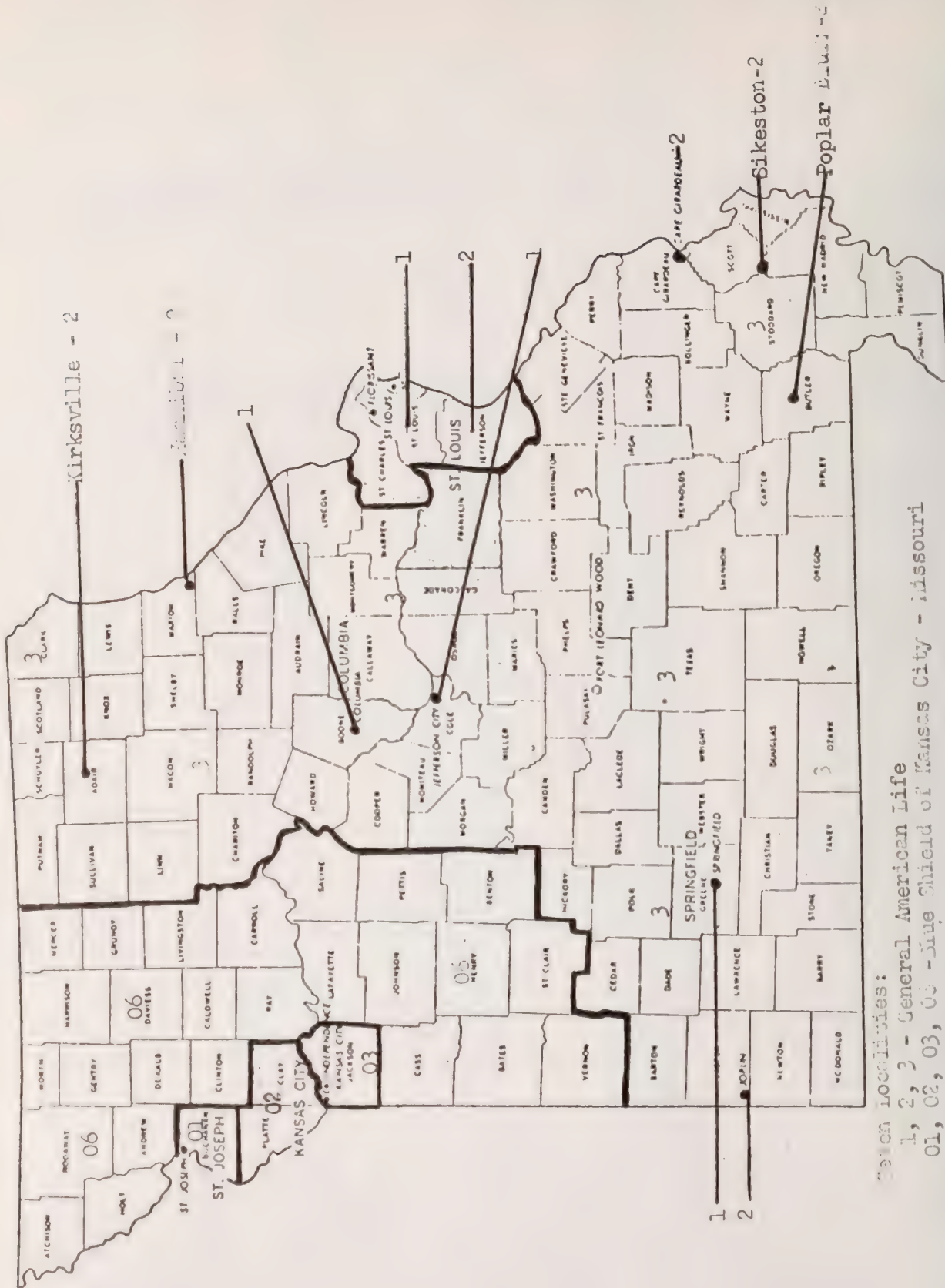
AREA 2

001	INITIAL BRIEF OFFICE VISIT					001
002	INITIAL LIMITED OFFICE VISIT				11.00	14.30*
003	INIT INTERMED OFFICE VISIT					002
004	INIT COMP OFFICE VISIT	14.30*	16.00	28.50*		003
005	MINIMAL F/U OFFICE VISIT	3.00	4.00*	6.50		004
006	BRIEF F/U OFFICE VISIT			10.00		005
007	LIMITED F/U OFFICE VISIT					006
008	INTERMED F/U OFFICE VISIT					007
009	EXTENDED F/U OFFICE VISIT					008
010	COMPLETE F/U OFFICE VISIT					009
011	BRIEF F/U HOME VISIT	14.30*	15.00*	14.30*		010
012	LIMITED F/U HOME VISIT					011
013	INTERMEDIATE F/U HOME VISIT					012
014	EXTENDED CARE FACILITY VISIT					013
015	BRIEF F/U NURSING HOME VISIT			10.00		014
016	INITIAL BRIEF HOSPITAL VISIT	21.30*	28.50*	30.00		015
017	INIT INTERMED HOSPITAL VISIT					016
018	INITIAL COMP HOSPITAL VISIT	21.30*	28.50	30.00		017
019	BRIEF F/U HOSPITAL VISIT	7.10*	7.50	7.10*		018
020	LIMITED F/U HOSPITAL VISIT					019
021	INTERMED F/U HOSPITAL VISIT					020
022	EXTENDED F/U HOSPITAL VISIT					021
023	BRIEF EMERGENCY ROOM VISIT			12.20*		022
024	LIMITED EMERGENCY ROOM VISIT			12.00		023
025	INTERMED EMERGENCY ROOM VISIT					024
026	LIMITED CONSULTATION	25.00	25.00			025
027	EXTENSIVE CONSULTATION			25.00		026
028	COMPREHENSIVE CONSULTATION			35.00		027
029	PSYCHOTHERAPY-ONE HOUR			40.00		028
030	PSYCHOTHERAPY-HALF HOUR			30.00		029
031	CHIROPRACTIC OFFICE VISIT	7.00*		20.00		030
032	INITIAL PHYSIOTHERAPY			7.25*		031
033	F/U PODIATRIC OFFICE VISIT			7.00		032
034	ELECTROCARDIOGRAM (EKG)	20.00	21.30*	20.00		033
035	EKG-INTERPRET REPORT ONLY	7.00	7.50	7.00		034
036	ARTERIAL BLOOD GAS STUDY					035
037	ELECTROENCEPHALOGRAPH (EEG)			45.00		036
038	CHEMOTHERAPY					037
039	COLLECTION OF SPECIMENS					038
040	DEBRIDEMENT OF NAILS			3.00		039
041	SKIN BIOPSY			15.00		040
042	CHEMOCAUTERY			20.00		041
043	RADICAL MASTECTOMY			13.00		042
044	OPEN REDUCTION OF FRACTURE			570.40*		043
045	ARTHRSCENTESIS-MAJOR JOINT			641.70*		044
046	ARTHROTOMY			13.40*		045
047	ARTHROPLASTY-REPAIR OF HIP	10.00	10.00	14.30*		046
048	NEEDLE PUNCTURE OF BURSA					047
049	BRONCHOSCOPY			128.30*		048
050	THORACENTESIS			32.90*		049

1979 PREVAILING CHARGE SUMMARY DATA THE TRAVELERS INSURANCE COMPANY MISSISSIPPI

PROCEDURE DESCRIPTION	AREA 1	AREA 2	LOCALITY DESIGNATION FOR GENERAL PRACTICE	LOCALITY DESIGNATION FOR SPECIALIST
051 CATHETERIZATION OF HEART				713.00*
052 INSERTION OF PACEMAKER				593.00*
053 PARTIAL COLECTOMY				370.60*
054 APPENDECTOMY				30.00
055 SIGMOIDOSCOPY	21.30*	20.00		258.60*
056 HEMORRHOIDECTOMY				525.00
057 CHOLECYSTECTOMY				350.00
058 REPAIR HERNIA				35.60*
059 DIAGNOSTIC CYSTOURETHROSCOPY	35.60*			14.30*
060 DILATION OF URETHRA				
061 PROSTATECTOMY				
062 ELECTROSECTION-PROSTATE (TUR)				
063 HYSTERECTOMY				600.00
064 INITIAL COMPLETE EYE EXAM				25.00
065 COMPREHENSIVE EYE EXAM				19.00
066 EYE EXAM WITH TONOMETRY				5.50*
067 EXTRACTION OF LENS				570.40*
068 CHEST X-RAY-SINGLE VIEW	14.30*	17.10*		15.00*
069 CHEST X-RAY-TWO VIEWS	20.00	20.00		21.30*
070 X-RAY SPINE				33.00
071 X-RAY HIP				21.30*
072 X-RAY UPPER GI TRACT				42.80*
073 X-RAY COLON		45.00		42.80*
074 RADIATION THERAPY-LOW VOLT				25.00
075 RADIATION THERAPY-SUPER VOLT				30.00
076 RADIATION THERAPY-MEGAVOLT				
077 CAT SCAN - HEAD				
078 CAT SCAN-HEAD-INTERPRET ONLY				
079 THREE CHEMISTRY TESTS				10.50
080 TWELVE CHEMISTRY TESTS				12.60
081 CULTURE-OTHER THAN BLOOD				10.00
082 HEMOGLOBIN				3.50
083 AUTOMATED BLOOD COUNT				
084 WHITE CELL COUNT				4.00
085 COMPLETE BLOOD COUNT (CBC)				9.00
086 CHOLESTEROL TEST				10.00
087 FLOCCULATION TEST				7.50
088 HEVATOCIT				4.00
089 PLATELET COUNT (REES-ECKER)				7.00
090 POTASSIUM TEST				8.00
091 PROTHROMBIN				7.00
092 SEDIMENTATION RATE				5.00
093 BLOOD SUGAR				6.00
094 SUN-UREA-NITROGEN				7.00
095 URIC ACID				8.00
096 FECES-OCCULT BLOOD				3.00
097 PAP TEST				10.00
098 ROUTINE URINALYSIS				4.00
099 CHEMICAL URINALYSIS				17.00
100 PATHOLOGY-THREE SPECIMENS				14.50

MISSOURI



Section Localities:

- 1, 2, 3 - General American Life
- 01, 02, 03, 06 - Blue Shield of Kansas City - Missouri

(For more locality information see Appendix A)

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

AREA 1

AREA 2

AREA 3

AREA 1

AREA 2

AREA 3

001 INITIAL BRIEF OFFICE VISIT				29.70*	23.50*	15.00	001
002 INITIAL LIMITED OFFICE VISIT	30.00	20.00	25.00	47.40*	35.00	35.60*	002
003 INIT INTERMED OFFICE VISIT				47.40*	35.00	35.60*	003
004 INIT COMP OFFICE VISIT	30.00	20.00	25.00	47.40*	35.00	35.60*	004
005 MINIMAL F/U OFFICE VISIT	3.30*	3.00	3.00	4.60*	4.20*	2.00	005
006 BRIEF F/U OFFICE VISIT	10.00*	9.20*	7.10*	12.80*	11.30*	9.70*	006
007 LIMITED F/U OFFICE VISIT	11.00*	10.30*	9.70*	13.50*	14.80*	10.00	007
008 INTERMED F/U OFFICE VISIT	24.60*	10.30*	10.00	30.00	14.60*	36.50*	008
009 EXTENDED F/U OFFICE VISIT	24.60*	15.70*	10.00	30.00	36.40*	36.50*	009
010 COMPLETE F/U OFFICE VISIT	45.00	26.80*	40.60*	43.10*	31.80*	45.00	010
011 BRIEF F/U HOME VISIT	15.00	14.30*	14.30*	14.00*	18.40*	14.30*	011
012 LIMITED F/U HOME VISIT				14.00*	18.40*	14.30*	012
013 INTERMED F/U HOME VISIT	15.00	14.30*	14.30*	14.00*	18.40*	14.30*	013
014 EXTENDED CARE FACILITY VISIT				12.00	10.00	9.70*	014
015 BRIEF F/U NURSING HOME VISIT	10.00	9.20*	7.10	12.00	10.00	9.70*	015
016 INITIAL BRIEF HOSPITAL VISIT	29.30*	30.60*	30.70*	37.40*	40.00	35.00	016
017 INIT INTERMED HOSPITAL VISIT				50.00	46.00	39.30*	017
018 INITIAL COMP HOSPITAL VISIT	35.00	39.70*	35.00	55.00	42.50*	30.00	018
019 BRIEF F/U HOSPITAL VISIT	12.00	11.30*	9.10*	14.10*	11.30*	10.70*	019
020 LIMITED F/U HOSPITAL VISIT	15.00	12.00	12.00	16.00	15.00	10.00	020
021 INTERMED F/U HOSPITAL VISIT	15.00	12.00	12.00	16.00	15.00	10.00	021
022 EXTENDED F/U HOSPITAL VISIT				20.00	20.00	10.00	022
023 BRIEF EMERGENCY ROOM VISIT				20.00	15.00	17.00*	023
024 LIMITED EMERGENCY ROOM VISIT				20.00	15.00	17.00*	024
025 INTERMED EMERGENCY ROOM VISIT				20.00	15.00	17.00*	025
026 LIMITED CONSULTATION	25.00	20.00	25.00	45.00*	37.20*	31.70*	026
027 EXTENSIVE CONSULTATION				60.00	37.20*	50.00	027
028 COMPREHENSIVE CONSULTATION				60.00	42.50*	50.00	028
029 PSYCHOTHERAPY-ONE HOUR				30.00	19.00	30.00	029
030 PSYCHOTHERAPY-HALF HOUR					12.50		030
031 CHIROPRACTIC OFFICE VISIT	10.00	8.00	10.00	10.00	8.00	7.80*	031
032 INITIAL PHYSIOTHERAPY				15.00	15.00	12.00	032
033 F/U PODIATRIC OFFICE VISIT				12.00	12.00	12.00	033
034 ELECTROCARDIOGRAM (ECG)	20.00	20.00	18.00	20.00	21.30*	20.00	034
035 EKG-INTERPRET-REPORT ONLY	6.70*	7.10*	6.00	9.00	7.10*	7.10*	035
036 ARTERIAL BLOOD GAS STUDY				38.30*	35.90*	40.00	036
037 ELECTROENCEPHALOGRAPH (EEG)				47.50*	44.70*	44.70*	037
038 CHEMOTHERAPY				15.60*	14.80*	14.70*	038
039 COLLECTION OF SPECIMENS				3.00	3.00	3.00	039
040 DEBRIDEMENT OF NAILS				11.10*	11.10*	11.10*	040
041 SKIN BIOPSY				25.00	25.00	25.00	041
042 CHEMOCAUTERY				17.50	16.00	15.00	042
043 RADICAL MASTECTOMY				650.00	623.20*	573.60*	043
044 OPEN REDUCTION OF FRACTURE				709.60*	691.00*	782.30*	044
045 ARTHROCENTESIS-MAJOR JOINT				16.00	20.00	20.00	045
046 ARTHROTOMY				16.00	10.00	12.50	046
047 ARTHROPLASTY-REPAIR OF HIP				950.00	937.50	912.50	047
048 NEEDLE PUNCTURE OF BURSA				12.00	12.00	15.00	048
049 CHOSCOPY				107.00*	142.60*	125.00	049
050 CENTESIS	15.00	12.00	10.00	50.00	35.60*	42.50*	050

PREVAILING CHARGE SUMMARY DATA GENERAL AMERICAN LIFE INSURANCE MISSOURI

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	AREA 1	AREA 2	AREA 3	AREA 1	AREA 2	AREA 3
051 CATHETERIZATION OF HEART				413.50*	419.10*	419.10*
052 INSERTION OF PACEMAKER				500.00	630.00	525.00
053 PARTIAL COLECTOMY				729.40*	630.00	606.20*
054 APPENDECTOMY				320.00	320.00	320.00
055 SIGMOIDOSCOPY	35.00	22.30*	29.20*	35.00	30.00	29.70*
056 HEMORRHOIDECTOMY				285.00*	267.40*	210.00
057 CHOLECYSTECTOMY				584.20*	496.30*	481.50*
058 REPAIR HERNIA				350.70*	301.20*	306.00*
059 DIAGNOSTIC CYSTOURETHROSCOPY	35.00	49.90*	49.90*	43.70*	47.10*	50.00
060 DILATION OF URETHRA				15.00	14.30*	15.00
061 PROSTATECTOMY				700.00	570.50*	511.80*
062 ELECTROSECTION-PROSTATE (TUR)	514.60*	500.00	500.00	600.00	570.50*	570.60*
063 HYSTERECTOMY				694.10*	535.00*	513.50*
064 INITIAL COMPLETE EYE EXAM				21.50	20.00*	17.90*
065 COMPREHENSIVE EYE EXAM				21.50	20.00*	17.90*
066 EYE EXAM WITH TONOMETRY				5.00	5.00	5.00
067 EXTRACTION OF LENS	726.40*	700.00	726.40*	725.50*	600.50*	614.60*
068 CHEST X-RAY, SINGLE VIEW	20.00	15.00	15.00	23.00	14.30*	18.60*
069 CHEST X-RAY, TWO VIEWS	25.00	23.90*	22.00	23.90*	20.00	20.00
070 X-RAY SPINE				35.00	24.00	30.70*
071 X-RAY HIP				21.00	21.00	21.00
072 X-RAY UPPER GI TRACT	33.00	42.00	38.00	60.00	42.80*	54.70*
073 X-RAY COLON				50.40*	38.00*	52.00*
074 RADIATION THERAPY-LOW VOLT	25.00	25.00	25.00	20.30*	17.70*	25.00
075 RADIATION THERAPY-SUPER VOLT	23.50	25.00	23.50	20.80	17.70*	25.00
076 RADIATION THERAPY-MEGAVOLT				23.50	17.70*	25.00
077 CAT SCAN - HEAD				233.50*	246.90*	300.00
078 CAT SCAN-HEAD, INTERPRET ONLY				35.00	35.00	35.00
079 THREE CHEMISTRY TESTS				17.00	24.00	24.00
080 TWELVE CHEMISTRY TESTS				20.00	13.00	13.00
081 CULTURE-OTHER THAN BLOOD				12.00	10.00	10.00
082 HEMOGLOBIN				3.00	3.00	3.00
083 AUTOMATED BLOOD COUNT				5.00	5.00	5.00
084 WHITE CELL COUNT				3.00	4.00	4.00
085 COMPLETE BLOOD COUNT (CBC)				9.00	8.00	8.00
086 CHOLESTEROL TEST				6.00	8.00	8.00
087 FLOCCULATION TEST				6.00	5.00	5.00
088 REYATOCRIT				4.00	3.00	3.00
089 PLATELET COUNT (REES-ECKER)				8.00	4.50	4.50
090 POTASSIUM TEST				7.00	8.00	8.00
091 PROTHROMBIN				6.00	7.50	7.50
092 SEDIMENTATION RATE				5.50	6.00	6.00
093 BLOOD SUGAR				6.00	7.50	7.50
094 BUN-UREA-NITROGEN				5.00	8.00	8.00
095 URIC ACID				5.60	8.00	8.00
096 FECES-OCULT BLOOD				4.00	5.00	5.00
097 PAP TEST				8.00	12.00	12.00
098 ROUTINE URINALYSIS				4.25	5.00	5.00
099 CHEMICAL URINALYSIS				1.00	1.00	1.00
100 PATHOLOGY-THREE SPECIMENS				17.50	12.00	12.00

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	AREA 01	AREA 02	AREA 03	AREA 06	AREA 01	AREA 02	AREA 03	AREA 06
001 INITIAL BRIEF OFFICE VISIT	25.00	25.00	45.00	20.00	35.90*	40.00*	45.00	40.00*
002 INITIAL LIMITED OFFICE VISIT					35.90*	40.00*	45.00	40.00*
003 INIT INTERMED OFFICE VISIT	25.00	25.00	45.00	20.00	35.90*	40.00*	45.00	40.00*
004 INIT COMP OFFICE VISIT	5.00	6.00	2.90*	5.00	35.90*	40.00*	45.00	40.00*
005 MINIMAL F/U OFFICE VISIT	10.00	10.00	11.30*	7.10*	7.10*	8.00*	7.10*	7.10
006 BRIEF F/U OFFICE VISIT	10.00	8.60*	11.30*	7.10*	7.10*	8.00*	7.10*	12.50
007 LIMITED F/U OFFICE VISIT	10.00	15.00	15.00	10.00	10.00*	14.30*	14.30*	12.50
008 INTERMED F/U OFFICE VISIT	15.00	17.00	12.00	10.00*	14.00	15.00	16.00	9.00
009 EXTENDED F/U OFFICE VISIT	20.00	28.50*	30.00	25.00	22.80*	22.80*	21.30*	22.80*
010 COMPLETE F/U OFFICE VISIT	18.00	12.00	15.00	11.30*	35.90*	35.60*	40.00	35.60*
011 BRIEF F/U HOME VISIT					18.00	12.00	15.00	11.30*
012 LIMITED F/U HOME VISIT					18.00	12.00	15.00	11.30*
013 INTERMED F/U HOME VISIT	20.00	17.10*	20.00	12.00	20.00	17.10*	20.00	12.00
014 EXTENDED CARE FACILITY VISIT					11.30*	20.00	21.30*	10.70*
015 BRIEF F/U NURSING HOME VISIT	10.00*	8.60*	11.30*	7.10*	10.00*	14.30*	14.30*	12.50*
016 INITIAL BRIEF HOSPITAL VISIT	25.00*	25.00*	35.00	35.00	30.75*	35.60*	35.60*	35.60*
017 INIT INTERMED HOSPITAL VISIT					49.90*	49.90*	55.00	35.60*
018 INITIAL COMP HOSPITAL VISIT	35.00	35.60*	49.90*	35.00	49.90*	49.90*	55.00	35.60*
019 BRIEF F/U HOSPITAL VISIT	14.30*	12.80*	14.30*	10.00	14.30*	16.00	14.30*	14.30*
020 LIMITED F/U HOSPITAL VISIT	14.30*	12.80*	14.30*	10.00	14.30*	16.00	14.30*	14.30*
021 INTERMED F/U HOSPITAL VISIT	15.00	11.30*	21.30*	20.00	17.10*	17.10*	17.00*	20.00*
022 EXTENDED F/U HOSPITAL VISIT					35.20*	45.00*	35.20*	35.20*
023 BRIEF EMERGENCY ROOM VISIT					21.30*	21.30*	21.30*	15.00
024 LIMITED EMERGENCY ROOM VISIT					21.30*	21.30*	21.30*	15.00
025 INTERMED EMERGENCY ROOM VISIT					21.30*	21.30*	21.30*	15.00
026 LIMITED CONSULTATION		40.00	40.00	35.00	35.60*	49.90*	49.90*	40.00
027 EXTENSIVE CONSULTATION					50.00*	60.00	71.30*	45.00
028 COMPREHENSIVE CONSULTATION					50.00*	60.00	71.30*	45.00
029 PSYCHOTHERAPY-ONE HOUR					55.60*	46.40*	58.00*	52.00
030 PSYCHOTHERAPY-HALF HOUR					27.80*	23.20*	29.00*	26.00
031 CHIROPRACTIC OFFICE VISIT					7.80*	8.50*	8.90*	7.80*
032 INITIAL PHYSIOTHERAPY					10.00	10.00	10.00	10.00
033 F/U PODIATRIC OFFICE VISIT					8.60*	10.00*	9.00*	8.00
034 ELECTROCARDIOGRAM (EKG)	15.00*	19.40*	18.40*	17.50	16.70*	23.00	20.00	17.50
035 EKG-INTERPRET-REPORT ONLY	13.35	8.10*	7.10*	7.10*	7.10*	9.00	9.00	9.00
036 ARTERIAL BLOOD GAS STUDY								
037 ELECTROENCEPHALOGRAM (EEG)					53.90		50.00	
038 CHEMOTHERAPY					21.10*	8.80*	23.70*	26.90*
039 COLLECTION OF SPECIMENS					3.00	3.00	3.00	3.00
040 DEBRIDEMENT OF NAILS					11.20*		12.00	12.00
041 SKIN BIOPSY					40.00	40.00	40.00	40.00
042 CHEMOCAUTERY								
043 RADICAL MASTECTOMY					641.70*	713.00*	713.00*	727.25*
044 OPEN REDUCTION OF FRACTURE					641.70*	713.00*	713.00*	625.00
045 ARTHROCENTESIS-MAJOR JOINT					16.00*	8.00	16.30*	16.00*
046 ARTHROTOMY					16.00*	8.00	16.30*	16.00*
047 ARTHROPLASTY-REPAIR OF HIP					855.60*	800.00	855.60*	855.60*
048 NEEDLE PUNCTURE OF BURSA					20.00	20.20	20.00	20.00
049 BRONCHOSCOPY					125.00*	151.50	155.00	107.00*
050 THORACENTESIS					35.60*	49.90*	49.90*	49.90*

REVENING CHARGE SUMMARY DATA B/S OF KANSAS CITY, MISSOURI

MISSOURI

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	AREA 01	AREA 02	AREA 03	AREA 06	AREA 01	AREA 02	AREA 03	AREA 06
051 CATHETERIZATION OF HEART					427.50	396.00	356.50*	450.00
052 INSERTION OF PACEMAKER					950.00	750.00	750.00	750.00
053 PARTIAL COLECTOMY					734.30*	734.30*	734.30*	713.00*
054 APPENDECTOMY					370.80*	370.80*	392.20*	370.80*
055 SIGMOIDOSCOPY	23.60*	21.30*	25.00	25.00	27.50	25.00*	35.60*	27.25*
056 HEMORRHOIDECTOMY					299.50*	299.50*	320.80*	299.50*
057 CHOLECYSTECTOMY					499.10*	570.40*	600.00	525.00
058 REPAIR HERNIA					350.00	356.50*	356.50*	249.60*
059 DIAGNOSTIC CYSTOURETHROSCOPY	47.50	53.50*	75.00	75.00*	71.30*	71.30*	71.30*	71.30*
060 DILATION OF URETHRA					17.00	15.90*	17.00	15.00
061 PROSTATECTOMY					713.00*	800.00	763.00*	713.00*
062 ELECTROSECTION-PROSTATE (TUR)	720.00	640.00	728.00	500.00	641.70*	641.70*	684.50*	641.70*
063 HYSTERECTOMY					641.70*	641.70*	650.00	591.70*
064 INITIAL COMPLETE EYE EXAM					22.80*	22.00*	25.00	20.00*
065 COMPREHENSIVE EYE EXAM					22.80*	22.00*	25.00	20.00*
066 EYE EXAM WITH TOMOMETRY					5.70*	5.70*	5.70*	5.70*
067 EXTRACTION OF LENS	750.00	640.00	728.00	664.00	641.70*	625.00	641.70*	641.70*
068 CHEST X-RAY-SINGLE VIEW	20.00	21.30*	20.00	15.00	14.30*	19.90*	16.50*	16.80
069 CHEST X-RAY-TWO VIEWS	25.00	21.30*	25.00	24.00	21.30*	21.30*	21.30*	23.00*
070 X-RAY SPINE					44.00	44.00	40.00	
071 X-RAY HIP					28.50*	26.50*	28.50*	
072 X-RAY UPPER GI TRACT	54.00	40.00	40.00	40.00	40.00*	40.00*	36.00	50.40
073 X-RAY COLON					39.90*	39.90*	39.90*	47.90*
074 RADIATION THERAPY-LOW VOLT								
075 RADIATION THERAPY-SUPER VOLT								
076 RADIATION THERAPY-MEGAVOLT								
077 CAT SCAN - HEAD						35.00	35.00	
078 CAT SCAN-HEAD-INTERPRET ONLY						35.00	35.00	
079 THREE CHEMISTRY TESTS								
080 TWELVE CHEMISTRY TESTS								
081 CULTURE-OTHER THAN BLOOD								
082 HEMOGLOBIN					15.00	15.00	15.00	15.00
083 AUTOMATED BLOOD COUNT					3.25	5.00	4.00	3.00
084 WHITE CELL COUNT					3.50	6.00	4.00	4.00
085 COMPLETE BLOOD COUNT (CBC)					3.75	10.00	9.00	9.00
086 CHOLESTEROL TEST					7.50	6.00	6.00	7.00
087 FLOCCULATION TEST								
088 HEMATOCRIT								
089 PLATELET COUNT (REES-ECKER)					3.25	5.00	3.50	3.00
090 POTASSIUM TEST					6.50	5.00	7.00	8.50
091 PROTHROMBIN					9.00	8.00	7.50	7.50
092 SEDIMENTATION RATE					6.00	7.00	7.00	6.00
093 BLOOD SUGAR					5.50	7.00	5.00	6.00
094 BUN-UREA-NITROGEN					7.50	6.00	7.00	6.50
095 URIC ACID					5.00	6.00	7.00	6.00
096 FECES-OCCULT BLOOD					7.50	6.00	7.00	7.50
097 PAP TEST					6.50	3.33	6.00	3.00
098 ROUTINE URINALYSIS					9.25	8.00	8.00	10.00
099 CHEMICAL URINALYSIS					5.00	6.00	6.00	4.50
100 PATHOLOGY-THREE SPECIMENS					5.00	6.00	6.00	23.70

MONTANA

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并

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

MT

MT

001 INITIAL BRIEF OFFICE VISIT	17.11*	001
002 INITIAL LIMITED OFFICE VISIT	25.50*	002
003 INIT INTERMED OFFICE VISIT	42.89*	003
004 INIT COMP OFFICE VISIT	49.91*	004
005 MINIMAL F/U OFFICE VISIT	7.63*	005
006 BRIEF F/U OFFICE VISIT	10.27*	006
007 LIMITED F/U OFFICE VISIT	14.30*	007
008 INTERMED F/U OFFICE VISIT	14.26*	008
009 EXTENDED F/U OFFICE VISIT	25.67*	009
010 COMPLETE F/U OFFICE VISIT	42.78*	010
011 BRIEF F/U HOME VISIT	17.00	011
012 LIMITED F/U HOME VISIT	21.45*	012
013 INTERMEDIATE F/U HOME VISIT	28.02*	013
014 EXTENDED CARE FACILITY VISIT	10.45	014
015 BRIEF F/U NURSING HOME VISIT	29.52*	015
016 INITIAL BRIEF HOSPITAL VISIT	42.78*	016
017 INIT INTERMED HOSPITAL VISIT	59.89*	017
018 INITIAL COMP HOSPITAL VISIT	10.27*	018
019 BRIEF F/U HOSPITAL VISIT	17.11*	019
020 LIMITED F/U HOSPITAL VISIT	23.83*	020
021 INTERMED F/U HOSPITAL VISIT	36.00	021
022 EXTENDED F/U HOSPITAL VISIT	16.20*	022
023 BRIEF EMERGENCY ROOM VISIT	24.78*	023
024 LIMITED EMERGENCY ROOM VISIT	26.74*	024
025 INTERMED EMERGENCY ROOM VISIT	42.78*	025
026 LIMITED CONSULTATION	59.89*	026
027 EXTENSIVE CONSULTATION	42.89*	027
028 COMPREHENSIVE CONSULTATION	25.73*	028
029 PSYCHOTHERAPY-ONE HOUR	10.48*	029
030 PSYCHOTHERAPY-HALF HOUR	13.34*	030
031 CHIROPRACTIC OFFICE VISIT	11.44*	031
032 INITIAL PHYSIOTHERAPY	25.67*	032
033 F/U PODIATRIC OFFICE VISIT	9.20*	033
034 ELECTROCARDIOGRAM (EKG)	53.38*	034
035 EKG-INTERPRET, REPORT ONLY	14.30*	035
036 ARTERIAL BLOOD GAS STUDY	5.00	036
037 ELECTROENCEPHALOGRAPH (EEG)	14.30*	037
038 CHEMOTHERAPY	20.59*	038
039 COLLECTION OF SPECIMENS	4.00*	039
040 DEBRIDEMENT OF NAILS	598.92*	040
041 SKIN BIOPSY	770.62*	041
042 CHEMOCAUTERY	21.00*	042
043 RADICAL MASTECTOMY	21.00*	043
044 OPEN REDUCTION OF FRACTURE	142.60*	044
045 ARTHROCENTESIS-MAJOR JOINT	27.75	045
046 ARTHROTOMY		046
047 ARTHROPLASTY-REPAIR OF HIP		047
048 NEEDLE PUNCTURE OF BURSA		048
049 BROMIDATION		049
050 THO.		050

79 PREVAILING CHARGE SUMMARY DATA

MONTANA PHYSICIANS SERVICE

MONTANA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

MT

MT

051 CATHETERIZATION OF HEART		430.77*	051
052 INSERTION OF PACEMAKER		874.89*	052
053 PARTIAL COLECTOMY		666.00	053
054 APPENDECTOMY		338.63*	054
055 SIGMOIDOSCOPY	20.80*	27.75*	055
056 HEMORRHOIDECTOMY		252.00	056
057 COLECTECTOMY		516.93*	057
058 REPAIR HERNIA		320.85*	058
059 CYSTOSCOPIC CYSTOURETHROSCOPY	44.00	42.00	059
060 DILATION OF URETHRA		14.00	060
061 PROSTATECTOMY		655.96*	061
062 ELECTROSECTION-PROSTATE (TUR)	673.07*	655.96*	062
063 HYSTERECTOMY		550.00	063
064 INITIAL COMPLETE EYE EXAM		28.12*	064
065 COMPREHENSIVE EYE EXAM		8.56*	065
066 EYE EXAM WITH TOMOMETRY		655.96*	066
067 EXTRACTION OF LENS		18.70	067
068 CHEST X-RAY, SINGLE VIEW	17.83*	25.67*	068
069 CHEST X-RAY, TWO VIEWS	25.20	55.61*	069
070 X-RAY SPINE		25.67*	070
071 X-RAY HIP		59.89*	071
072 X-RAY UPPER GI TRACT		59.89*	072
073 X-RAY COLON		51.34*	073
074 RADIATION THERAPY-LOW VOLT		29.26*	074
075 RADIATION THERAPY-SUPER VOLT		36.79*	075
076 RADIATION THERAPY-MEGAVOLT		36.79*	076
077 CAT SCAN - HEAD		150.00	077
078 CAT SCAN-HEAD, INTERPRET ONLY		95.31*	078
079 THREE CHEMISTRY TESTS			079
080 TWELVE CHEMISTRY TESTS			080
081 CULTURE-OTHER THAN BLOOD		6.60	081
082 HEMOGLOBIN		3.00	082
083 ASSOCIATED BLOOD COUNT		7.50	083
084 WHITE CELL COUNT		3.00	084
085 COMPLETE BLOOD COUNT (CBC)		10.00	085
086 CHOLESTEROL TEST		8.00	086
087 FLOCCULATION TEST		4.20	087
088 REYNOTECRIT		3.00	088
089 PLATELET COUNT (REES-ECKER)		7.00	089
090 POTASSIUM TEST		9.30	090
091 PROTHROMBIN		6.00	091
092 SEDIMENTATION RATE		5.50	092
093 BLOOD SUGAR		7.00	093
094 SUI-URICA-NITROGEN		8.13	094
095 URIC ACID		7.20	095
096 FECS-OCULT BLOOD		4.25	096
097 PAP TEST		10.00	097
098 ROUTINE URINALYSIS		4.75	098
099 CHEMICAL URINALYSIS		3.00	099
100 PATHOLOGY-THREE SPECIMENS		27.07	100

NEBRASKA

[illegible]

Three Localities.

- 1 - Douglas and Lancaster Counties
- 3 - Counties over 25,000 population - Adams, Buffalo, Dodge, Gage,
Hall, Lincoln, Madison, Platte, Sarpy, Scotts Bluff
- 4 - Remaining 81 counties under 25,000 population

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

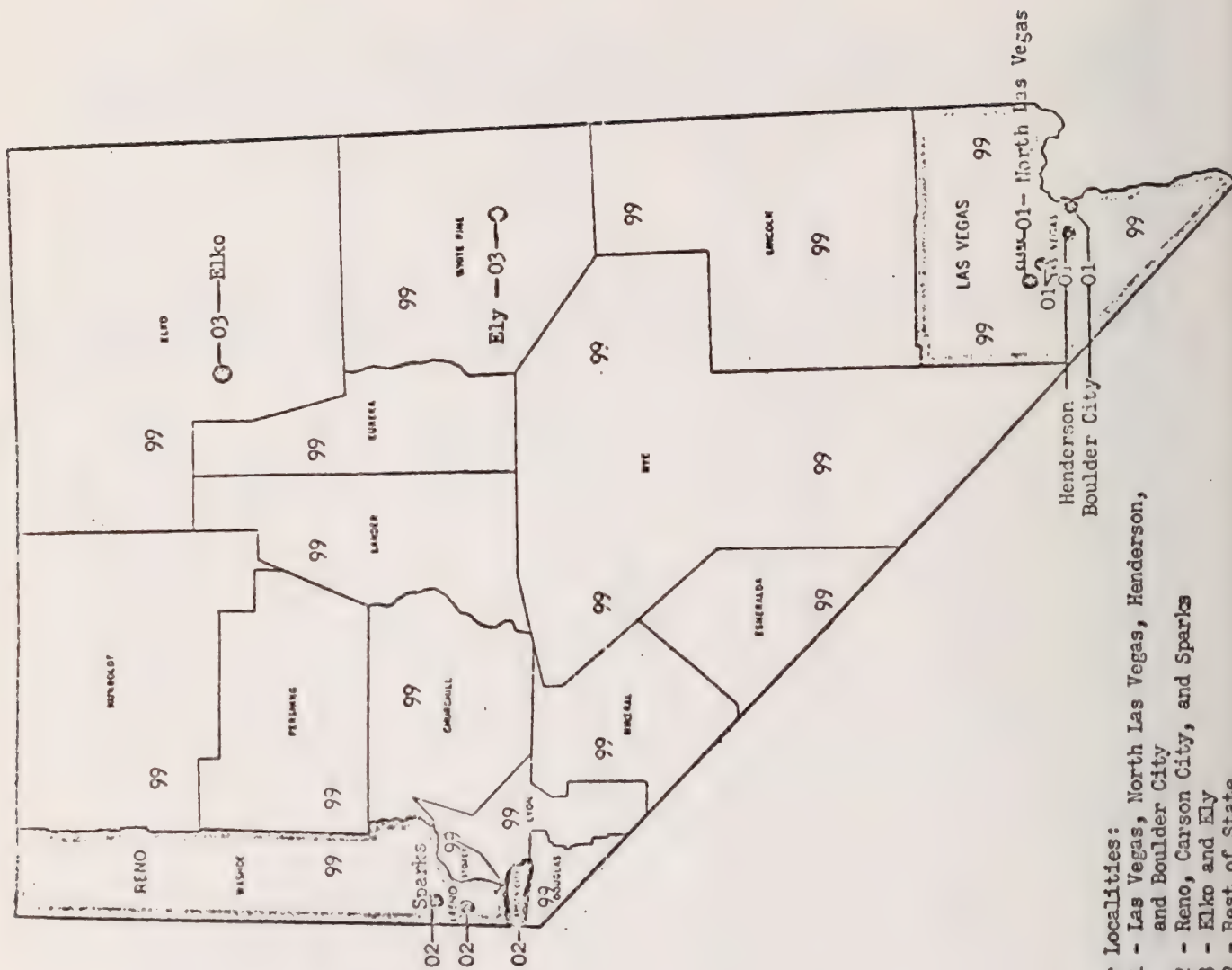
PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE				LOCALITY DESIGNATION FOR SPECIALIST			
	AREA 1	AREA 3	AREA 4		AREA 1	AREA 3	AREA 4	
001 INITIAL BRIEF OFFICE VISIT					11.30*	8.60*	20.00*	001
002 INITIAL LIMITED OFFICE VISIT	10.25	10.00	10.00		12.80*	12.00	10.00	002
003 INIT INTERMED OFFICE VISIT					12.80*	12.00	10.00	003
004 INIT COMP OFFICE VISIT	40.00	35.00	35.00		50.00	40.00	49.90*	004
005 MINIMAL F/U OFFICE VISIT	8.60*	8.60*	7.10*		11.30*	8.60*	7.10*	005
006 BRIEF F/U OFFICE VISIT	8.60*	8.60*	7.10*		11.30*	8.60*	7.10*	006
007 LIMITED F/U OFFICE VISIT	10.25	10.00	10.00		12.80*	12.00	10.00	007
008 INTERMED F/U OFFICE VISIT	10.25	10.00	10.00		12.80*	12.00	10.00	008
009 EXTENDED F/U OFFICE VISIT	12.00	10.00	10.00		14.30*	14.30*	10.00	009
010 COMPLETE F/U OFFICE VISIT	40.00	35.00	35.00		50.00	40.00	49.90*	010
011 BRIEF F/U HOME VISIT	10.00*	14.30*	14.30*		21.40	14.30*	14.30*	011
012 LIMITED F/U HOME VISIT					18.00*	14.30*	14.30*	012
013 INTERMEDIATE F/U HOME VISIT	21.00	18.00	15.00		15.00	15.00	15.00	013
014 EXTENDED CARE FACILITY VISIT					10.00	10.00	15.00	014
015 BRIEF F/U NURSING HOME VISIT	8.60*	8.60*	7.10*		11.30*	8.60*	7.10*	015
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	27.00	21.40*		42.80*	30.00*	25.00	016
017 INIT INTERMED HOSPITAL VISIT					42.80*	30.00*	25.00	017
018 INITIAL COMP HOSPITAL VISIT	50.00	40.00	40.00		57.10*	50.00	57.10*	018
019 BRIEF F/U HOSPITAL VISIT	10.00	8.60*	8.60*		12.20*	10.00	8.60*	019
020 LIMITED F/U HOSPITAL VISIT	10.00	8.60*	8.60*		12.20*	10.00	8.60*	020
021 INTERMED F/U HOSPITAL VISIT	10.00	10.00	10.00		14.30*	12.00	14.30*	021
022 EXTENDED F/U HOSPITAL VISIT					21.40*	28.50*	25.00	022
023 BRIEF EMERGENCY ROOM VISIT					20.00	15.00	15.00	023
024 LIMITED EMERGENCY ROOM VISIT					20.00	15.00	15.00	024
025 INTERMED EMERGENCY ROOM VISIT					38.90*	41.40*	37.70*	025
026 LIMITED CONSULTATION	21.40*	21.40*	20.00		25.00*	30.00*	35.00	026
027 EXTENSIVE CONSULTATION					35.60*	40.00	37.50	027
028 COMPREHENSIVE CONSULTATION					57.10*	50.00	60.00	028
029 PSYCHOTHERAPY-ONE HOUR					60.00	60.00	60.00	029
030 PSYCHOTHERAPY-HALF HOUR					30.00	30.00	30.00	030
031 CHIROPRACTIC OFFICE VISIT	8.60*	8.60*	7.10*		7.60*	5.00	8.00	031
032 INITIAL PHYSIOTHERAPY					20.00	20.00	18.00	032
033 F/U PODIATRIC OFFICE VISIT					10.00	8.60*	7.10*	033
034 ELECTROCARDIOGRAM (EKG)	21.40*	20.00	20.00		21.40*	20.00	20.00	034
035 EKG-INTERPRET. REPORT ONLY	10.70*	10.00	10.00		10.70*	10.00	10.00	035
036 ARTERIAL BLOOD GAS STUDY					26.00	26.00	22.50	036
037 ELECTROENCEPHALOGRAPH (EEG)					55.00	55.00	55.00	037
038 CHEMOTHERAPY								038
039 COLLECTION OF SPECIMENS					5.25	5.25	5.25	039
040 DEBRIDEMENT OF NAILS					12.00	11.30*	11.30*	040
041 SKIN BIOPSY					20.00	20.00	20.00	041
042 CHEMOCAUTERY					15.00*	15.00	15.00*	042
043 RADICAL MASTECTOMY					641.90*	500.00	606.20*	043
044 OPEN REDUCTION OF FRACTURE					670.00	627.60*	570.60*	044
045 ARTHROCENTESIS-MAJOR JOINT					15.00	15.00*	14.30*	045
046 ARTHROCENTESIS					15.00	15.00*	14.30*	046
047 ARTHROCENTESIS-REPAIR OF					760.00	720.00	740.00	047
048 NEEDLE PUNCTURE OF CURSA					15.00	15.00*	14.30*	048
049 BRONCHOSCOPY					142.60*	142.60*	142.60*	049
050 THORACENTESIS					35.60*	35.60*	35.60*	050

979 PREVAILING CHARGE SCHEDULE DATA MEDICAL INSURANCE CO. SPECIALIST

PROCEDURE DESCRIPTION	AREA 1	AREA 3	AREA 4	LOCALITY DESIGNATION FOR GENERAL PRACTICE	LOCALITY DESIGNATION FOR SPECIALIST
051 CATHETERIZATION OF HEART				AREA 1	AREA 4
052 INSERTION OF PACEMAKER				325.00*	280.00
053 PARTIAL COLECTOMY				750.00*	700.00
054 APPENDECTOMY				713.20*	713.20*
055 SIGMOIDOSCOPY				300.00	300.00
056 HEMORRHOIDECTOMY				21.40*	21.40*
057 CHOLECYSTECTOMY				256.80*	256.80*
058 REPAIR HERNIA				495.00	427.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY				342.30*	285.30*
060 DILATION OF URETHRA				40.00	40.00
061 PARTIAL PROSTATECTOMY				15.00*	16.00
062 ELECTROSECTION-PROSTATE (TUR)				627.60*	627.60*
063 HYSTERECTOMY				570.60*	570.60*
064 INITIAL COMPLETE EYE EXAM				641.20*	570.60*
065 COMPREHENSIVE EYE EXAM				20.00	21.40*
066 EYE EXAM WITH TOMOGRAPHY				21.40*	24.00
067 EXTRACTION OF LENS				12.00	13.80
068 CHEST X-RAY, SINGLE VIEW				499.20*	517.50
069 CHEST X-RAY, TWO VIEWS				21.00*	18.75
070 X-RAY SPINE				540.00	24.90*
071 X-RAY HIP				17.90*	45.00
072 X-RAY UPPER GI TRACT				20.00	29.30*
073 X-RAY COLON				50.00*	34.40*
074 RADIATION THERAPY-LOW VOLT				64.10*	52.50
075 RADIATION THERAPY-SUPER VOLT				55.00	45.00
076 RADIATION THERAPY-MEGAVOLT				20.00	30.00
077 CAT SCAN - HEAD				275.00	23.00
078 CAT SCAN-HEAD, INTERPRET ONLY				60.00	236.70*
079 THREE CHEMISTRY TESTS				19.00	54.90
080 TWELVE CHEMISTRY TESTS				6.00	17.40
081 CULTURE-OTHER THAN BLOOD				4.00	9.00
082 HEMOGLOBIN				11.00	4.00
083 DIFFERENTIAL BLOOD COUNT				4.00	8.00
084 WHITE CELL COUNT				11.00	4.50
085 COMPLETE BLOOD COUNT (CBC)				11.00	8.00
086 CHOLESTEROL TEST				5.00	7.50
087 FLOCCULATION TEST				4.00	3.50
088 HEMATOCRIT				6.00	6.00
089 PLATELET COUNT (REES-ECKER)				7.80	7.40
090 POTASSIUM TEST				7.00	6.00
091 PROTHROMBIN				4.00	4.50
092 SEGMENTATION RATE				7.00	6.50
093 BLOOD SUGAR				7.50	7.00
094 BUN-UREA-NITROGEN				8.00	8.00
095 URIC ACID				3.70	4.00
096 FECES-OCCULT BLOOD				10.00	11.50
097 PAP TEST				5.10	7.50
098 ROUTINE URINALYSIS				1.50	5.00
099 CHEMICAL URINALYSIS				18.00	4.00
100 PATHOLOGY-THREE SPECIMENS					17.50

NEVADA

NEVADA



Four Localities:

- 01 - Las Vegas, North Las Vegas, Henderson, and Boulder City
- 02 - Reno, Carson City, and Sparks
- 03 - Elko and Ely
- 99 - Rest of State

(The city boundaries are the exact boundaries of the localities.)

1979 PREVAILING CHARGE SUMMARY DATA

AETNA LIFE AND CASUALTY

NEVADA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

01 02 03 99

01 02 03 99

001 INITIAL BRIEF OFFICE VISIT
 002 INITIAL LIMITED OFFICE VISIT
 003 INIT INTERMED OFFICE VISIT
 004 INIT COMP OFFICE VISIT
 005 MINIMAL F/U OFFICE VISIT
 006 BRIEF F/U OFFICE VISIT
 007 LIMITED F/U OFFICE VISIT
 008 INTERMED F/U OFFICE VISIT
 009 EXTENDED F/U OFFICE VISIT
 010 COMPLETE F/U OFFICE VISIT
 011 BRIEF F/U HOME VISIT
 012 LIMITED F/U HOME VISIT
 013 INTERMEDIATE F/U HOME VISIT
 014 EXTENDED CARE FACILITY VISIT
 015 BRIEF F/U NURSING HOME VISIT
 016 INITIAL BRIEF HOSPITAL VISIT
 017 INIT INTERMED HOSPITAL VISIT
 018 INITIAL COMP HOSPITAL VISIT
 019 BRIEF F/U HOSPITAL VISIT
 020 LIMITED F/U HOSPITAL VISIT
 021 INTERMED F/U HOSPITAL VISIT
 022 EXTENDED F/U HOSPITAL VISIT
 023 BRIEF EMERGENCY ROOM VISIT
 024 LIMITED EMERGENCY ROOM VISIT
 025 INTERMED EMERGENCY ROOM VISIT
 026 LIMITED CONSULTATION
 027 EXTENSIVE CONSULTATION
 028 COMPREHENSIVE CONSULTATION
 029 PSYCHOTHERAPY-ONE HOUR
 030 PSYCHOTHERAPY-HALF HOUR
 031 CHIROPRACTIC OFFICE VISIT
 032 INITIAL PHYSIOTHERAPY
 033 F/U PODIATRIC OFFICE VISIT
 034 ELECTROCARDIOGRAM (EKG)
 035 EKG-INTERPRET. REPORT ONLY
 036 ARTERIAL BLOOD GAS STUDY
 037 ELECTROENCEPHALOGRAM (EEG)
 038 CHEMOTHERAPY
 039 COLLECTION OF SPECIMENS
 040 DEBRIDEMENT OF NAILS
 041 SKIN BIOPSY
 042 CHEMOCAUTERY
 043 RADICAL MASTECTOMY
 044 OPEN REDUCTION OF FRACTURE
 045 ARTHROCTESIS-MAJOR JOINT
 046 ARTHROTOMY
 047 ARTHROPLASTY-REPAIR OF HIP
 048 NEEDLE PUNCTURE OF BURSA
 049 BRONCHOSCOPY
 050 THORACENTESIS

30.00 26.00 25.00 25.00
 55.00 50.00 68.40 55.00
 7.20* 7.20 7.20* 6.00
 14.30* 11.40* 10.70* 11.40*
 15.00 15.00 14.50 15.00
 20.00 22.80* 20.00 17.00
 30.00 32.50 30.00 30.00
 45.60* 45.60* 45.60* 45.60*
 25.00 21.30* 20.00 21.30*
 35.60* 28.50* 34.20 34.20*
 14.30 11.40 10.70 10.70*
 35.60* 35.60* 35.60* 30.00
 75.00 65.00 75.00 75.00
 14.30* 14.30* 13.60* 11.40*
 20.00 15.00 20.00 20.00
 25.00 25.00 25.00 25.00
 35.60* 35.00 34.20 35.00
 20.00 12.00 17.10* 13.30
 30.00 30.00 35.60* 28.50*
 25.00 21.30* 21.30* 20.00*
 25.00 21.30* 22.50 1512.50
 21.30* 22.50 22.80* 25.80
 179.70* 171.10* 192.50* 193.50
 40.00 40.00 33.60 38.70

001 21.30* 18.00 22.80* 25.00
 002 35.00 42.50 40.00 40.00
 003 35.00 35.00 35.00 35.00
 004 75.00 63.00 79.20 95.40
 005 7.35* 8.60* 8.60* 12.70
 006 14.30* 15.00 12.20* 15.00*
 007 20.00 18.00 20.00 20.00
 008 20.00 18.00 20.00 20.00
 009 30.00 35.00 35.00 35.00
 010 46.30* 45.50 46.30* 46.30*
 011 25.00 25.40 25.40 26.20
 012 50.00 38.10 38.10 39.30
 013 50.00 38.10 38.10 39.30
 014 18.00 20.00 15.00 18.00
 015 14.30 15.00 12.20 15.00
 016 35.00 28.00 35.00 47.70
 017 65.00 50.00 49.90* 57.00
 018 95.60* 65.00 79.90* 95.40
 019 20.00 17.00 16.50 20.00
 020 25.00 18.00 20.00 31.80
 021 25.00 25.00 25.00 25.00
 022 30.00 28.00 39.60 47.70
 023 30.00 22.10* 26.40 30.00
 024 30.00 30.00 46.20 30.00
 025 35.00 35.00 66.00 79.50
 026 35.60* 35.60* 35.60* 47.70
 027 71.40* 45.00 49.90* 79.50
 028 85.60* 66.00 79.90* 111.30
 029 65.00 61.30* 62.50 62.50
 030 35.00 25.40* 37.50 37.50
 031 12.00 12.70* 12.00 12.00
 032 15.60 15.00 15.00 15.00
 033 15.00 14.30* 11.40 11.40
 034 28.50* 28.00 28.00 23.00
 035 87.50 79.10 92.40 111.30
 036 74.20 70.00 74.20 74.20
 037 25.00 13.00 33.00 39.80
 038 3.00 3.00 3.00 3.00
 039 15.00 15.00 22.40 25.80
 040 30.00 31.00 33.60 38.70
 041 16.00 18.00 22.40 25.80
 042 839.40* 898.30* 784.00 903.00
 043 1215.00 912.60* 1056.00 968.00
 044 21.30* 22.50 39.60 21.30*
 045 21.30* 24.00 26.40 24.20
 046 1587.50 1525.00 1650.00 1512.50
 047 21.30* 22.50 22.80* 25.80
 048 179.70* 171.10* 192.50* 193.50
 049 40.00 40.00 33.60 38.70
 050

1979 PREVAILING CHARGE SUMMARY DATA

NEVADA

AETNA LIFE AND CASUALTY

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	99	01	02	03	99
051 CATHETERIZATION OF HEART					400.00	297.70*	441.00	441.00
052 INSERTION OF PACEMAKER					920.00	900.00	980.00	980.00
053 PARTIAL COLECTOMY					1026.60*	1026.60*	912.60*	1032.00
054 APPENDECTOMY					479.10*	513.40*	448.00	516.00
055 Sigmoidoscopy	36.00	35.00	28.50	25.00	42.80*	34.00	35.00	33.70
056 Hemorrhoidectomy					352.20*	359.40*	342.10*	387.00
057 Cholecystectomy					784.30*	763.00*	684.50*	784.30*
058 Repair Hernia					499.10*	456.30*	399.30*	519.60*
059 Diagnostic Cystourethroscopy	56.00	49.50	47.50	43.50	75.00	75.00	65.50	65.50
060 Dilation of Urethra					20.00	20.00	39.30	39.30
061 Prostatectomy					912.60*	958.30*	1048.00	1048.00
062 Electrosection-Prostate (TUR)	395.00	792.00	760.00	696.00	958.30*	1120.00	1048.00	1048.00
063 Hysterectomy					838.40*	838.40*	945.00	945.00
064 Initial Complete Eye Exam					36.00	30.00	32.00	40.40
065 Comprehensive Eye Exam					45.00	35.50*	45.00	50.50
066 Eye Exam with Tonometry					13.50*	12.00	11.60*	10.10
067 Extraction of Lens	895.00	792.00	760.00	696.00	926.90*	912.60*	926.90*	912.00
068 Chest X-Ray, Single View	21.30*	21.30*	17.70	17.10*	17.10*	17.10*	21.80	21.20
069 Chest X-Ray, Two Views	28.00	25.70*	29.00	21.30*	25.70*	32.00	32.00	31.80
070 X-Ray Spine					33.00	30.90*	32.70	31.80
071 X-Ray Hip					28.50*	31.50	43.60	42.40
072 X-Ray Upper GI Tract	61.60*	57.00*	57.60	52.80	61.50*	69.00	67.00	63.60
073 X-Ray Colon					51.30*	65.00	65.00	53.00
074 Radiation Therapy-Low Volt	29.10	28.80	28.80	26.40	27.60	31.20	32.70	31.80
075 Radiation Therapy-Super Volt	33.80	38.40	38.40	35.20	36.80	41.60	43.60	42.40
076 Radiation Therapy-Megavolt								
077 CAT Scan - Head					110.40	124.80	130.80	127.20
078 CAT Scan-Head, Interpret Only								
079 Three Chemistry Tests					28.00*	24.00*	24.00*	24.00*
080 Twelve Chemistry Tests					26.00*	26.40*	26.00*	26.00*
081 Culture-Other Than Blood					10.00*	9.00*	10.00*	10.00*
082 Hemoglobin					5.00*	4.90*	6.00*	5.00*
083 Automated Blood Count					6.10	5.00	6.20	6.10
084 White Cell Count					4.50*	3.00*	10.00*	4.50*
085 Complete Blood Count (CBC)					10.00*	9.75*	13.00*	13.50*
086 Cholesterol Test					9.00*	12.50*	10.00*	10.00*
087 Flocculation Test					5.00*	6.00*	6.00*	6.00*
088 Hematocrit					4.00*	3.00*	6.00*	4.00*
089 Platelet Count (Rees-Ecker)					7.50*	6.00*	7.50*	7.50*
090 Potassium Test					8.00*	6.00*	7.00*	7.00*
091 Prothrombin					7.50*	6.00*	8.50*	6.25*
092 Sedimentation Rate					6.00*	5.00*	6.00*	6.00*
093 Blood Sugar					9.00*	7.00*	8.50*	10.00*
094 Bun-Urea, Nitrogen					8.00*	8.00*	12.40	8.00*
095 Uric Acid					10.00*	7.00*	10.00*	10.00*
096 Feces-Occult Blood					2.00*	5.00*	3.00*	3.00*
097 PAP Test					10.00*	8.50*	10.00*	8.00*
098 Routine Urinalysis					5.60*	5.00*	6.00*	5.00*
099 Chemical Urinalysis					5.00*	5.00*	5.00*	5.00*
100 Pathology-Three Specimens								

NEW HAMPSHIRE

NEW HAMPSHIRE



One Locality - Statewide

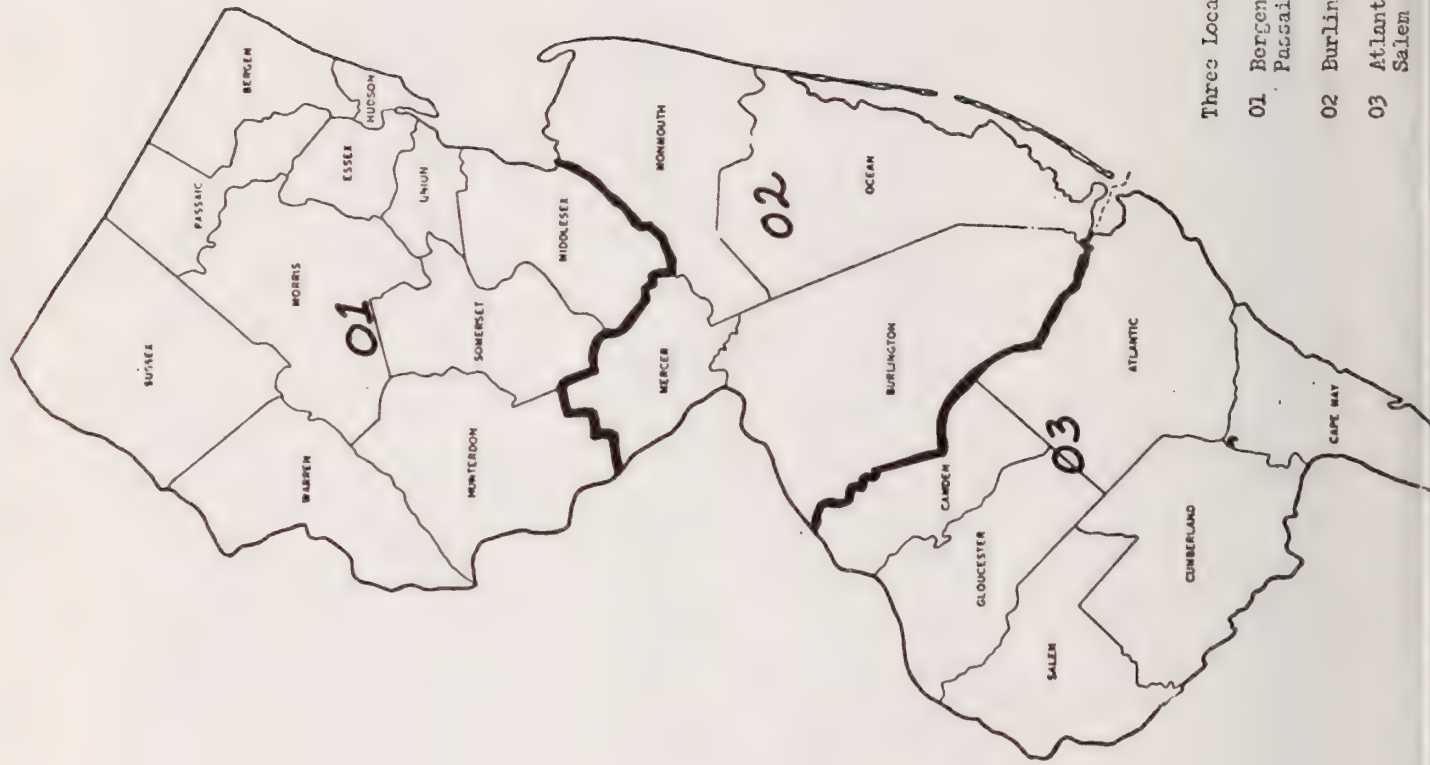
LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	01
001 INITIAL BRIEF OFFICE VISIT		
002 INITIAL LIMITED OFFICE VISIT	13.00	16.00
003 INIT INTERMED OFFICE VISIT		20.00
004 INIT COMP OFFICE VISIT	20.00	35.70*
005 MINIMAL F/U OFFICE VISIT	5.00*	5.70*
006 BRIEF F/U OFFICE VISIT	10.00*	11.40*
007 LIMITED F/U OFFICE VISIT	14.30*	15.00
008 INTERMED F/U OFFICE VISIT		
009 EXTENDED F/U OFFICE VISIT	20.00	35.00
010 COMPLETE F/U OFFICE VISIT	14.30*	17.10*
011 BRIEF F/U HOME VISIT		
012 LIMITED F/U HOME VISIT	14.30*	24.50
013 INTERMEDIATE F/U HOME VISIT		11.40*
014 EXTENDED CARE FACILITY VISIT		13.00
015 BRIEF F/U NURSING HOME VISIT	8.00*	35.00
016 INITIAL BRIEF HOSPITAL VISIT	30.00	
017 INIT INTERMED HOSPITAL VISIT		
018 INITIAL COMP HOSPITAL VISIT	30.70*	35.70*
019 BRIEF F/U HOSPITAL VISIT	10.00*	14.30*
020 LIMITED F/U HOSPITAL VISIT		
021 INTERMED F/U HOSPITAL VISIT	14.30*	21.00
022 EXTENDED F/U HOSPITAL VISIT		20.00
023 BRIEF EMERGENCY ROOM VISIT		5.70*
024 LIMITED EMERGENCY ROOM VISIT		14.30*
025 INTERMED EMERGENCY ROOM VISIT		
026 LIMITED CONSULTATION	29.40*	35.00
027 EXTENSIVE CONSULTATION		35.70*
028 COMPREHENSIVE CONSULTATION		35.70*
029 PSYCHOTHERAPY-ONE HOUR		40.00
030 PSYCHOTHERAPY-HALF HOUR		21.40*
031 CHIROPRACTIC OFFICE VISIT	14.00	9.00
032 INITIAL PHYSIOTHERAPY		
033 F/U PODIATRIC OFFICE VISIT		10.00
034 ELECTROCARDIOGRAM (EKG)	20.00	15.43*
035 EKG-INTERPRET. REPORT ONLY	18.00	10.03*
036 ARTERIAL BLOOD GAS STUDY		49.00
037 ELECTROENCEPHALOGRAM (EEG)		50.00*
038 CHEMOTHERAPY		12.00
039 COLLECTION OF SPECIMENS		
040 DEBRIDEMENT OF NAILS		10.70*
041 SKIN BIOPSY		21.40*
042 CHEMOCAUTERY		
043 RADICAL MASTECTOMY		598.90*
044 OPEN REDUCTION OF FRACTURE		750.00
045 ARTHROCENTESIS-MAJOR JOINT		17.10*
046 ARTHROTOMY		21.40*
047 ARTHROPLASTY-REPAIR OF HIP	15.00	700.00
048 NEEDLE PUNCTURE OF BURSA		10.70*
049 BRONCHOSCOPY		142.60*
050 THORACENTESIS		35.00

1979 PREVAILING CHARGE SUMMARY DATA			NEW HAMPSHIRE-VERMONT B/S		NEW HAMPSHIRE	
			LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
PROCEDURE DESCRIPTION	01	01				
051 CATHETERIZATION OF HEART					270.00	051
052 INSERTION OF PACEMAKER					789.60	052
053 PARTIAL COLECTOMY					650.00	053
054 APPENDECTOMY					338.70*	054
055 SCLEROSCOPY	25.00				30.00	055
056 HEMORRHOIDECTOMY					499.10*	056
057 CHOLECYSTECTOMY					320.90*	057
058 REPAIR HERNIA					70.00	058
059 DIAGNOSTIC CYSTOURETHROSCOPY	38.64				21.40*	059
060 DILATION OF URETHRA					584.50*	060
061 PROSTATECTOMY					675.00	061
062 ELECTROSECTION-PROSTATE (TUR)	644.00				500.00	062
063 HYSTERECTOMY					14.30*	063
064 INITIAL COMPLETE EYE EXAM					10.00	064
065 COMPREHENSIVE EYE EXAM					570.40*	065
066 EYE EXAM WITH TONOMETRY					15.00	066
067 EXTRACTION OF LENS					22.00	067
068 CHEST X-RAY, SINGLE VIEW					29.40	068
069 CHEST X-RAY, TWO VIEWS					22.00	069
070 X-RAY SPINE					45.00*	070
071 X-RAY HIP					40.00	071
072 X-RAY UPPER GI TRACT					14.30*	072
073 X-RAY COLON					14.30*	073
074 RADIATION THERAPY-LOW VOLT						074
075 RADIATION THERAPY-SUPER VOLT						075
076 RADIATION THERAPY-MEGAVOLT						076
077 CAT SCAN - HEAD						077
078 CAT SCAN-HEAD, INTERPRET ONLY						078
079 THREE CHEMISTRY TESTS						079
080 TWELVE CHEMISTRY TESTS						080
081 CULTURE-OTHER THAN BLOOD						081
082 HEMOGLOBIN					5.00	082
083 AUTOMATED BLOOD COUNT					3.50	083
084 WHITE CELL COUNT					2.00	084
085 COMPLETE BLOOD COUNT (CBC)					3.00	085
086 CHOLESTEROL TEST					8.00	086
087 FLOCCULATION TEST					7.00	087
088 HEVACCRIT					5.00	088
089 PLATELET COUNT (REES-ECKER)					4.00	089
090 POTASSIUM TEST					6.00	090
091 PROTHROMBIN					5.50	091
092 SEDIMENTATION RATE					3.70	092
093 BLOOD SUGAR					6.00	093
094 BUN-UREA-NITROGEN					6.00	094
095 URIC ACID					7.00	095
096 FECES-OCULT BLOOD					3.00	096
097 PAP TEST					7.00	097
098 ROUTINE URINALYSIS					5.00	098
099 CHEMICAL URINALYSIS					3.00	099
100 PATHOLOGY-THREE SPECIMENS					21.00	100

NEW JERSEY

NEW JERSEY



Three Localities:

- 01 Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union, Warren Counties
- 02 Burlington, Mercer, Monmouth, and Ocean Counties
- 03 Atlantic, Camden, Cape May, Cumberland, Gloucester, Salem Counties

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	01	02	03
001 INITIAL BRIEF OFFICE VISIT	21.40*	25.00*	20.00	14.30*	14.30*	14.30*
002 INITIAL LIMITED OFFICE VISIT				35.70*	28.50*	28.50*
003 INIT INTERMED OFFICE VISIT	30.00*	28.50*	28.50*	42.80*	42.80*	35.70*
004 INIT COMP OFFICE VISIT	11.40*	11.40*	10.00*	14.30*	14.30*	14.30*
005 MINIMAL F/U OFFICE VISIT	11.40*	11.40*	10.00*	14.30*	14.30*	14.30*
006 BRIEF F/U OFFICE VISIT	11.40*	11.40*	10.00*	14.30*	14.30*	14.30*
007 LIMITED F/U OFFICE VISIT	25.00	20.00	15.00	35.00	35.00	25.00
008 INTERMED F/U OFFICE VISIT	25.00	20.00	15.00	35.00	35.00	25.00
009 EXTENDED F/U OFFICE VISIT	25.00	20.00	15.00	35.00	35.00	25.00
010 COMPLETE F/U OFFICE VISIT	17.10*	14.30*	14.30*	17.10*	17.10*	14.30*
011 BRIEF F/U HOME VISIT				17.10*	17.10*	14.30*
012 LIMITED F/U HOME VISIT	17.10*	14.30*	14.30*	17.10*	17.10*	14.30*
013 INTERMEDIATE F/U HOME VISIT				21.40*	12.00	21.40*
014 EXTENDED CARE FACILITY VISIT	17.10*	14.30*	15.00	49.90*	49.90*	15.00
015 BRIEF F/U NURSING HOME VISIT	35.00	35.00	35.00	49.90*	49.90*	42.80*
016 INITIAL BRIEF HOSPITAL VISIT				35.70*	35.70*	39.90*
017 INIT INTERMED HOSPITAL VISIT	35.70*	35.00	35.70*	17.10*	15.00*	14.30*
018 INITIAL COMP HOSPITAL VISIT	14.30*	14.30*	14.30*	17.10*	15.00*	14.30*
019 BRIEF F/U HOSPITAL VISIT	25.00	25.00	21.40*	30.00	25.00	28.50*
020 INTERMED F/U HOSPITAL VISIT				30.00	25.00	28.50*
021 EXTENDED F/U HOSPITAL VISIT				21.40*	21.40*	21.40*
022 BRIEF EMERGENCY ROOM VISIT				21.40*	21.40*	21.40*
023 LIMITED EMERGENCY ROOM VISIT	15.00	20.00	20.00	20.00	20.00	20.00
024 INTERMED EMERGENCY ROOM VISIT				71.30*	50.00*	55.00
025 LIMITED CONSULTATION				75.00	60.00	60.00
026 EXTENSIVE CONSULTATION				49.90*	42.80*	49.90*
027 COMPREHENSIVE CONSULTATION				33.00	28.50*	28.50*
028 PSYCHOTHERAPY-ONE HOUR				12.00	12.00	10.00
029 PSYCHOTHERAPY-HALF HOUR				40.00	40.00	40.00
030 PSYCHOPRACTICE OFFICE VISIT				14.30*	14.30*	11.40*
031 INITIAL PHYSIOTHERAPY				25.00	25.00	25.00
032 F/U PODIATRIC OFFICE VISIT	25.00	25.00	25.00	10.00	20.00	7.50*
033 EKG-INTERPRET-REPORT ONLY	10.00	10.00	10.00	65.00	65.00	65.00
034 ELECTROCARDIOGRAM (EKG)				49.90*	57.00*	57.00*
035 ARTERIAL BLOOD GAS STUDY				21.40*	17.10*	28.50*
036 ELECTROENCEPHALOGRAPH (EEG)				8.50*	6.00	5.00
037 CHEMOTHERAPY				15.00	14.00	14.00
038 COLLECTION OF SPECIMENS				50.00	35.00	45.00
039 DEBRIDEMENT OF NAILS				20.00	21.40*	21.40*
040 SKIN BIOPSY				855.60*	855.60*	725.00
041 CHEMOCAUTERY				910.00	926.90*	955.40*
042 RADICAL MASTECTOMY				10.00	40.00	13.00
043 OPEN REDUCTION OF FRACTURE				20.00	20.00	20.00
044 ARTHROCENTESIS-MAJOR JOINT				729.20*	729.20*	729.20*
045 ARTHROTOMY				20.00	21.00	22.00
046 ARTHROPLASTY-REPAIR OF HIP	20.00	18.00	18.00	213.90*	249.60*	157.50*
047 ARTHROPLASTY-REPAIR OF HIP				75.00*	71.30*	57.00*
048 NEEDLE PUNCTURE OF BURSA						
049 BRONCHOSCOPY						
050 THORACENTESIS						

1979 PREVAILING CHARGE SUMMARY DATA PRUDENTIAL INSURANCE COMPANY

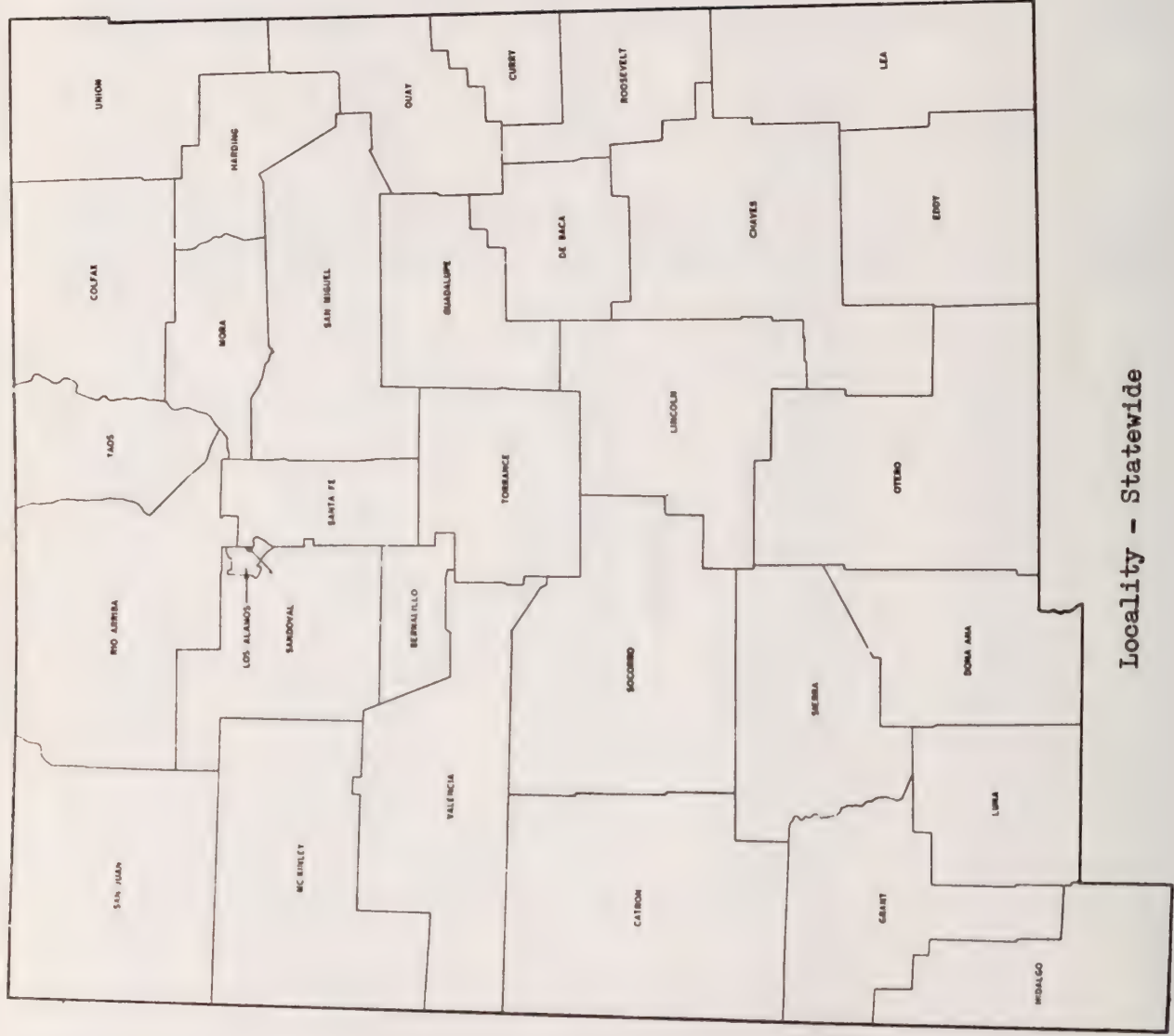
NEW JERSEY

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	01	02	03
051 CATHETERIZATION OF HEART				427.80*	427.80*	427.80*
052 INSERTION OF PACEMAKER				1069.50*	1025.00	1069.50*
053 PARTIAL COLECTOMY				1069.50*	998.20*	855.60*
054 APPENDECTOMY				449.20*	456.30*	392.20*
055 SIGMOIDOSCOPY	25.00	25.00	25.00	49.90*	49.90*	49.90*
056 HEMORRHOIDECTOMY				392.20*	356.50*	306.60*
057 CHOLECYSTECTOMY				713.00*	670.20*	570.40*
058 REPAIR HERNIA				442.10*	427.80*	356.50*
059 DIAGNOSTIC CYSTOURETHROSCOPY	65.00	71.30*	71.30*	64.20*	71.30*	64.20*
060 DILATION OF URETHRA				21.40*	20.00	15.00
061 PROSTATECTOMY				993.20*	855.60*	748.70*
062 ELECTROSECTION-PROSTATE (TUR)	704.30*	784.30*	784.30*	855.60*	934.00	713.00*
063 HYSTERECTOMY				800.00	713.00*	850.00
064 INITIAL COMPLETE EYE EXAM				25.00	24.00	24.00
065 COMPREHENSIVE EYE EXAM				23.00	27.20	40.00*
066 EYE EXAM WITH TONOMETRY				14.30*	14.30*	14.30*
067 EXTRACTION OF LENS	784.30*	784.30*	750.00	855.60*	713.00*	713.00*
068 CHEST X-RAY, SINGLE VIEW	7.00	7.00	8.60*	7.00	7.00	8.60*
069 CHEST X-RAY, TWO VIEWS	10.00	9.00	10.00	8.60*	9.00*	8.60*
070 X-RAY SPINE				16.50	18.00	14.00
071 X-RAY HIP				11.00	12.00	12.00
072 X-RAY UPPER GI TRACT	27.50	27.50	27.50	25.70*	27.50	27.50
073 X-RAY COLON				25.00	25.00	25.00
074 RADIATION THERAPY-LOW VOLT	5.90*	8.90*	8.90*	8.70*	8.70*	8.70*
075 RADIATION THERAPY-SUPER VOLT	18.00	18.00	18.00	18.00	18.00	18.00
076 RADIATION THERAPY-MEGAVOLT				20.00	20.00	20.00
077 CAT SCAN - HEAD				150.00	150.00	150.00
078 CAT SCAN-HEAD, INTERPRET ONLY				75.00	75.00	75.00
079 THREE CHEMISTRY TESTS				8.75	15.00	8.75
080 TWELVE CHEMISTRY TESTS				15.00	15.00	17.00
081 CULTURE-OTHER THAN BLOOD				13.40	10.00	10.00
082 HEMOGLOBIN				3.25	4.00	6.00
083 AUTOMATED BLOOD COUNT				8.00	8.00	8.00
084 WHITE CELL COUNT				4.00	4.00	1.00
085 COMPLETE BLOOD COUNT (CBC)				8.00	8.00	8.00
086 CHOLESTEROL TEST				6.00	6.50	7.00
087 FLOCCULATION TEST				5.00	6.50	6.00
088 HEMATOCRIT				5.00	5.00	5.00
089 PLATELET COUNT (REES-ECKER)				5.20	5.00	5.00
090 POTASSIUM TEST				6.50	8.00	8.00
091 PROTHROMBIN				5.00	6.00	6.00
092 SEDIMENTATION RATE				5.00	5.50	5.00
093 BLOOD SUGAR				6.00	6.50	6.00
094 BUN-UREA, NITROGEN				6.00	6.50	6.00
095 URIC ACID				6.00	6.50	6.10*
096 FECES-OCCULT BLOOD				5.00	5.00	5.00
097 PAP TEST				8.00	10.00	9.00
098 ROUTINE URINALYSIS				5.00	5.00	4.00
099 CHEMICAL URINALYSIS				5.00	5.00	4.00
100 PATHOLOGY-THREE SPECIMENS				20.00	25.00	15.00

NEW MEXICO

NEW MEXICO



Locality - Statewide

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

SINGLE

SINGLE

001	INITIAL BRIEF OFFICE VISIT			18.60*	001
002	INITIAL LIMITED OFFICE VISIT	29.70*		36.50	002
003	INIT INTERMED OFFICE VISIT			36.50	003
004	INIT COMP OFFICE VISIT	32.50		52.10*	004
005	MINIMAL F/U OFFICE VISIT	5.90*		8.20*	005
006	BRIEF F/U OFFICE VISIT	10.40*		11.90*	006
007	LIMITED F/U OFFICE VISIT	14.80*		16.30*	007
008	INTERMED F/U OFFICE VISIT	17.80*		27.37	008
009	EXTENDED F/U OFFICE VISIT	30.45		31.80*	009
010	COMPLETE F/U OFFICE VISIT	31.20		48.20*	010
011	BRIEF F/U HOME VISIT	14.80*		22.30*	011
012	LIMITED F/U HOME VISIT			31.35	012
013	INTERMEDIATE F/U HOME VISIT	31.60*		36.58	013
014	EXTENDED CARE FACILITY VISIT			11.10*	014
015	BRIEF F/U NURSING HOME VISIT	10.40*		11.90*	015
016	INITIAL BRIEF HOSPITAL VISIT	20.85		27.37	016
017	INIT INTERMED HOSPITAL VISIT			39.30*	017
018	INITIAL COMP HOSPITAL VISIT	52.00*		55.70*	018
019	BRIEF F/U HOSPITAL VISIT	8.90*		11.10*	019
020	LIMITED F/U HOSPITAL VISIT	14.80*		16.00*	020
021	INTERMED F/U HOSPITAL VISIT	24.40		24.40	021
022	EXTENDED F/U HOSPITAL VISIT			36.49	022
023	BRIEF EMERGENCY ROOM VISIT			10.00	023
024	LIMITED EMERGENCY ROOM VISIT			19.60*	024
025	INTERMED EMERGENCY ROOM VISIT			23.25*	025
026	LIMITED CONSULTATION	22.30*		31.80*	026
027	EXTENSIVE CONSULTATION			44.50*	027
028	COMPREHENSIVE CONSULTATION			59.40*	028
029	PSYCHOTHERAPY-ONE HOUR			48.70	029
030	PSYCHOTHERAPY-HALF HOUR			31.35	030
031	CHIROPRACTIC OFFICE VISIT	9.50*		9.90*	031
032	INITIAL PHYSIOTHERAPY			23.35	032
033	F/U PODIATRIC OFFICE VISIT			11.90*	033
034	ELECTROCARDIOGRAM (EKG)	22.30*		22.40*	034
035	EKG-INTERPRET REPORT ONLY	11.40*		12.00	035
036	ARTERIAL BLOOD GAS STUDY			12.00	036
037	ELECTROENCEPHALOGRAPH (EEG)			55.69*	037
038	CHEMOTHERAPY				038
039	COLLECTION OF SPECIMENS			3.00	039
040	DEBRIDEMENT OF NAILS			10.43	040
041	SKIN BIOPSY			23.60*	041
042	CHEMOCAUTERY			24.10*	042
043	RADICAL MASTECTOMY			723.90*	043
044	OPEN REDUCTION OF FRACTURE			743.40*	044
045	ARTHROCENTESIS-MAJOR JOINT			24.14	045
046	ARTHROTOMY			20.85	046
047	ARTHROPLASTY-REPAIR OF HIP			980.00	047
048	NEEDLE PUNCTURE OF BURSA			21.50*	048
049	BRONCHOSCOPY			185.40*	049
050	THORACENTESIS			37.10*	050

1979 PREVAILING CHARGE SUMMARY DATA			EQUITABLE LIFE ASSURANCE SOCIETY		NEW MEXICO		
LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST					
PROCEDURE DESCRIPTION		SINGLE		SINGLE			
051	CATHERIZATION OF HEART			401.40		051	
052	INSERTION OF PACEMAKER			1080.00		052	
053	PARTIAL COLECTOMY			750.60		053	
054	APPENDECTOMY			400.60*		054	
055	SIGMOIDOSCOPY	32.00		31.05		055	
056	HEMORRHOIDECTOMY			290.40*		056	
057	CHOLECYSTECTOMY			593.40*		057	
058	REPAIR HERNIA			368.60*		058	
059	DIAGNOSTIC CYSTOURETHROSCOPY	52.00*		52.00*		059	
060	DILATION OF URETHRA			29.40		060	
061	PROSTATECTOMY			729.75		061	
062	ELECTROSECTION-PROSTATE (TUR)	499.00		720.00		062	
063	HYSTECTOMY			707.00*		063	
064	INITIAL COMPLETE EYE EXAM			20.10*		064	
065	COMPREHENSIVE EYE EXAM			20.10*		065	
066	EYE EXAM WITH TONOMETRY			10.10*		066	
067	EXTRACTION OF LENS			694.00*		067	
068	CHEST X-RAY, SINGLE VIEW	780.00		17.60*		068	
069	CHEST X-RAY, TWO VIEWS	15.30*		22.40*		069	
070	X-RAY SPINE	22.30*		29.70*		070	
071	X-RAY HIP			29.50*		071	
072	X-RAY UPPER GI TRACT			55.25*		072	
073	X-RAY COLON			52.00*		073	
074	RADIATION THERAPY-LOW VOLT			18.60*		074	
075	RADIATION THERAPY-SUPER VOLT	24.30		20.85		075	
076	RADIATION THERAPY-MEGAVOLT	32.40		20.85		076	
077	CAT SCAN - HEAD			234.56		077	
078	CAT SCAN-HEAD, INTERPRET ONLY			78.19		078	
079	THREE CHEMISTRY TESTS					079	
080	TWELVE CHEMISTRY TESTS					080	
081	CULTURE-OTHER THAN BLOOD					081	
082	CRYSTALLIN			10.50		082	
083	AUTOMATED BLOOD COUNT			4.17		083	
084	WHITE CELL COUNT			9.12		084	
085	COMPLETE BLOOD COUNT (CBC)			4.17		085	
086	CHOLESTEROL TEST			3.62		086	
087	FLOCCULATION TEST			11.47		087	
088	HEMATOCRIT			4.00		088	
089	PLATELET COUNT (REES-ECKER)			3.65		089	
090	POTASSIUM TEST			7.62		090	
091	BUN,UREA,NITROGEN			6.25		091	
092	SEDIMENTATION RATE			7.70		092	
093	BLOOD SUGAR			5.22		093	
094	BUN-UREA,NITROGEN			7.30		094	
095	URIC ACID			7.70		095	
096	FECES-OCULT BLOOD			8.84		096	
097	PAP TEST			3.14		097	
098	ROUTINE URINALYSIS			10.43		098	
099	CHEMICAL URINALYSIS			5.21		099	
100	PATHOLOGY-THREE SPECIMENS			4.05		100	
				41.13			

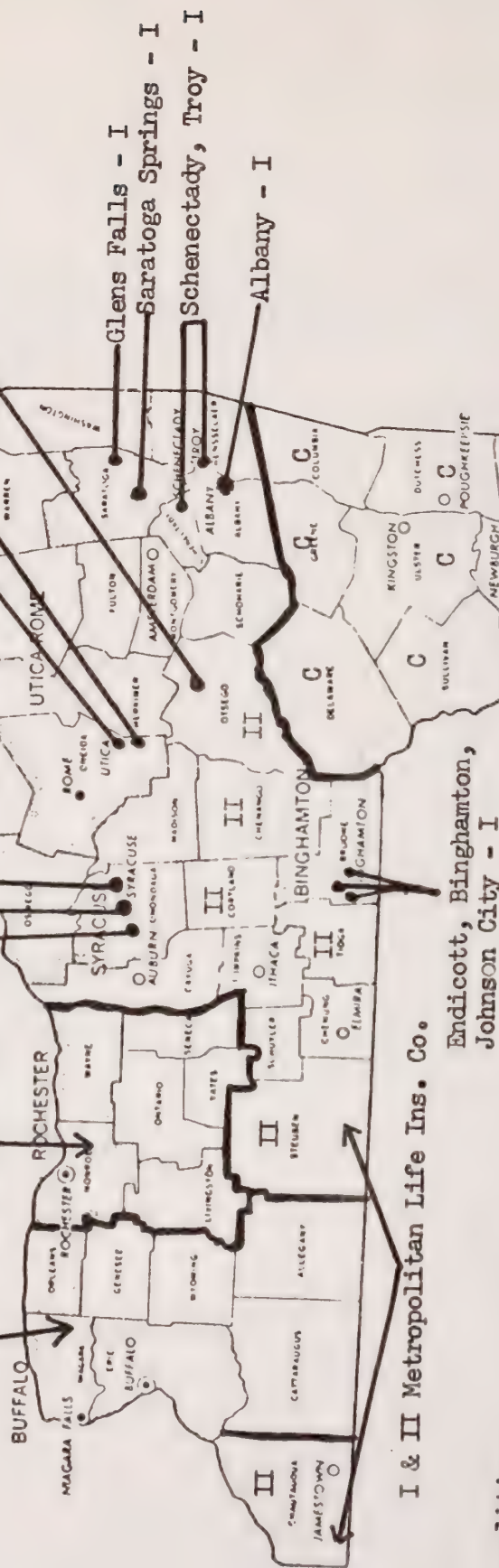
NEW YORK

NEW YORK

- I - Ogdensburg
- I - Fayetteville
- I - Syracuse
- I - Marcellus

B/S of Western New York

Genesee Valley Medical Care, Inc.



I & II Metropolitan Life Ins. Co.

Endicott, Binghamton,
Johnson City - I

8 Localities:

- B/S of Greater New York - A, B, & C
- Metropolitan Life Insurance Co. - I & II
- Group Health Insurance - Queens County
- B/S of Western New York - Allegheny, Cattaraugus, Erie, Genesee, Niagara, Orleans & Wyoming Counties
- Genesee Valley Medical Care Inc. - Livingston, Monroe, Seneca, Wayne & Yates Counties

(For more locality information see Appendix A)

Note: Geographic areas administered by Metropolitan Life Insurance Co. will be transferred to B/S of Western New York effective August 1, 1979.
Geographic areas administered by Genesee Valley Medical Care will be transferred to B/S of Western New York effective October 1, 1979.

Group Health Insurance

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

A

B

C

A

B

C

001 INITIAL BRIEF OFFICE VISIT	17.10*	14.30*	11.40*	28.50*	21.40*	15.00*	001
002 INITIAL LIMITED OFFICE VISIT				28.50*	21.40*	15.00*	002
003 INIT INTERMED OFFICE VISIT	17.10*	25.00*	21.40*	49.90*	35.00*	28.50*	003
004 INIT COMP OFFICE VISIT	17.10*	14.30*	11.40*	28.50*	21.40*	15.00*	004
005 MINIMAL F/U OFFICE VISIT	17.10*	14.30*	11.40*	28.50*	21.40*	15.00*	005
006 BRIEF F/U OFFICE VISIT	17.10*	14.30*	11.40*	28.50*	21.40*	15.00*	006
007 LIMITED F/U OFFICE VISIT	17.10*	14.30*	11.40*	28.50*	21.40*	15.00*	007
008 INTERMED F/U OFFICE VISIT	17.10*	14.30*	11.40*	28.50*	21.40*	15.00*	008
009 EXTENDED F/U OFFICE VISIT	25.70*	21.40*	15.00*	35.70*	28.50*	25.00*	009
010 COMPLETE F/U OFFICE VISIT	21.40*	21.40*	15.00*	35.70*	28.50*	25.00*	010
011 BRIEF F/U HOME VISIT	21.40*	21.40*	15.00*	35.70*	21.40*	15.00*	011
012 LIMITED F/U HOME VISIT	21.40*	21.40*	15.00*	35.70*	21.40*	15.00*	012
013 INTERMEDIATE F/U HOME VISIT	21.40*	21.40*	15.00*	35.70*	21.40*	15.00*	013
014 EXTENDED CARE FACILITY VISIT	17.10*	14.30*	11.40*	28.50*	21.40*	15.00*	014
015 BRIEF F/U NURSING HOME VISIT	28.50*	25.00*	21.40*	50.00*	38.00*	30.00*	015
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	25.00*	21.40*	50.00*	38.00*	30.00*	016
017 INIT INTERMED HOSPITAL VISIT	28.50*	25.00*	21.40*	50.00*	38.00*	30.00*	017
018 INITIAL COMP HOSPITAL VISIT	28.50*	25.00*	21.40*	50.00*	38.00*	30.00*	018
019 BRIEF F/U HOSPITAL VISIT	21.40*	17.10*	14.30*	35.00*	21.40*	15.00*	019
020 LIMITED F/U HOSPITAL VISIT	21.40*	17.10*	14.30*	35.00*	21.40*	15.00*	020
021 INTERMED F/U HOSPITAL VISIT	21.40*	17.10*	14.30*	35.00*	21.40*	15.00*	021
022 EXTENDED F/U HOSPITAL VISIT	71.30*	50.00*	35.70*	71.30*	50.00*	35.70*	022
023 BRIEF EMERGENCY ROOM VISIT				30.00*	28.50*	25.00*	023
024 LIMITED EMERGENCY ROOM VISIT				30.00*	28.50*	25.00*	024
025 INTERMED EMERGENCY ROOM VISIT				30.00*	28.50*	25.00*	025
026 LIMITED CONSULTATION	71.30*	50.00*	35.70*	71.30*	50.00*	35.70*	026
027 EXTENSIVE CONSULTATION				71.30*	50.00*	35.70*	027
028 COMPREHENSIVE CONSULTATION				71.30*	50.00*	35.70*	028
029 PSYCHOTHERAPY-ONE HOUR				71.30*	50.00*	35.70*	029
030 PSYCHOTHERAPY-HALF HOUR				71.30*	50.00*	35.70*	030
031 CHIROPRACTIC OFFICE VISIT	11.30*	11.10*	10.00*	13.00*	11.10*	10.00*	031
032 INITIAL PHYSIOTHERAPY				20.00*	15.00*	11.40*	032
033 F/U PODIATRIC OFFICE VISIT				28.50*	21.40*	15.00*	033
034 ELECTROCARDIOGRAM (EKG)	22.50*	28.50*	25.00*	30.80*	28.50*	25.00*	034
035 EKG-INTERPRET-REPORT ONLY	16.80*	13.80*	10.00*	18.50*	14.00*	10.00*	035
036 ARTERIAL BLOOD GAS STUDY				10.00*	10.00*	10.00*	036
037 ELECTROENCEPHALOGRAM (EEG)				90.00*	64.20*	49.90*	037
038 CHEMOTHERAPY				42.80*	50.00*	25.00*	038
039 COLLECTION OF SPECIMENS							039
040 DESLIME OF NAILS							040
041 SKIN BIOPSY				50.00*	45.00*	45.00*	041
042 CHEMOCAUTERY				64.20*	60.00*	35.00*	042
043 SURGICAL MASTECTOMY				1426.00*	1212.10*	713.00*	043
044 OPEN REDUCTION OF FRACTURE				1652.00*	1428.00*	1069.50*	044
045 SURGICAL REPAIR OF JOINT				49.90*	35.70*	36.00*	045
046 SURGICAL REPAIR OF TENDON				35.70*	35.70*	29.00*	046
047 ARTHROPLASTY-REPAIR OF HIP	28.50*	23.10*	23.80*	3000.00*	2500.00*	2000.00*	047
048 NEEDLE PUNCTURE OF BURSA				49.90*	35.70*	42.80*	048
049 SURGICAL DEBRIDEMENT				285.20*	250.00*	213.90*	049
050 SURGICAL DEBRIDEMENT				92.70*	107.00*	60.00*	050

PREVAILING CHARGE SUMMARY DATA B/C-B/S OF GREATER NEW YORK

NEW YORK

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	A	B	C	A	B	C
051 CATHETERIZATION OF HEART				665.00	500.00*	385.00*
052 INSERTION OF PACEMAKER						
053 PARTIAL COLECTOMY				1782.50*	1426.00*	1069.50*
054 APPENDECTOMY				784.00*	641.70*	427.80*
055 SIGMOIDOSCOPY	35.70*	35.00	35.00*	49.90*	35.70*	42.80*
056 HEMORRHOIDECTOMY				641.70*	534.75*	400.00*
057 CHOLECYSTECTOMY				1212.10*	891.25*	641.70*
058 REPAIR HERNIA				775.00*	570.40*	427.80*
059 DIAGNOSTIC CYSTOURETHROSCOPY	75.00	75.00*	64.20*	114.10*	107.00*	71.30*
060 DILATION OF URETHRA				35.00	25.00*	20.00
061 PROSTATECTOMY				1426.00*	1140.80*	919.80*
062 ELECTROSECTION-PROSTATE (TUR)	1140.80*	1069.50*	1069.50*	1176.50*	1069.50*	1069.50*
063 HYSTERECTOMY				1212.10*	1059.50*	784.30*
064 INITIAL COMPLETE EYE EXAM				35.70*	28.50*	30.00
065 COMPREHENSIVE EYE EXAM				28.40*	23.40*	25.20*
066 EYE EXAM WITH TONOMETRY				28.50*	21.40*	15.00*
067 EXTRACTION OF LENS				1069.50*	978.80*	749.50*
068 CHEST X-RAY, SINGLE VIEW	784.30*	636.60*	636.60*	25.00	25.00	21.40*
069 CHEST X-RAY, TWO VIEWS	25.00	21.40*	21.40*	35.70*	35.00	28.50*
070 X-RAY SPINE	35.70*	35.00		64.20*	55.00*	50.00
071 X-RAY HIP				40.00	35.70	31.50*
072 X-RAY UPPER GI TRACT	107.00*	85.00	73.60*	107.00*	85.00	80.00
073 X-RAY COLON				107.00*	85.00	65.00
074 RADIATION THERAPY-LOW VOLT	20.00	20.00	20.00	49.90*	30.00	17.50
075 RADIATION THERAPY-SUPER VOLT	15.70*	35.70*	21.40*	42.80*	35.70*	17.50
076 RADIATION THERAPY-MEGAVOLT				42.80*	35.70*	17.50
077 CAT SCAN - HEAD				167.70*	163.40*	213.90*
078 CAT SCAN-HEAD, INTERPRET ONLY				28.00*	27.20*	35.70*
079 THREE CHEMISTRY TESTS						
080 TWELVE CHEMISTRY TESTS				18.00	15.00	15.00
081 CULTURE-OTHER THAN BLOOD				20.00	20.00	20.00
082 HEMOGLOBIN				5.00	5.00	4.00
083 AUTOMATED BLOOD COUNT				14.00	14.00	14.00
084 WHITE CELL COUNT				5.00	4.00	5.00
085 COMPLETE BLOOD COUNT (CBC)				10.00	9.00	10.00
086 CHOLESTEROL TEST				8.00	7.00	7.00
087 FLOCCULATION TEST				6.00	6.00	6.00
088 HEMATOCRIT				5.00	5.00	5.00
089 PLATELET COUNT (REES-ECKER)				6.00	6.00	6.00
090 POTASSIUM TEST				10.00	8.00	7.00
091 PROTHROMBIN				10.00	7.00	7.00
092 SEDIMENTATION RATE				6.00	5.00	5.00
093 BLOOD SUGAR				7.50	7.00	6.00
094 BUN-UREA, NITROGEN				8.00	7.00	7.00
095 URIC ACID				8.00	7.00	7.00
096 FECES-OCCULT BLOOD				5.00	5.00	5.00
097 PAP TEST				10.00	10.00	8.00
098 ROUTINE URINALYSIS				6.00	5.00	5.00
099 CHEMICAL URINALYSIS				5.00	5.00	5.00
100 PATHOLOGY-THREE SPECIMENS				20.00	20.00	20.00

1979 PREVAILING CHARGE SUMMARY DATA METROPOLITAN LIFE INSURANCE CO. NEW YORK

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	AREA I		AREA II		AREA I		AREA II	
001 INITIAL BRIEF OFFICE VISIT					21.40*		20.00	001
002 INITIAL LIMITED OFFICE VISIT					42.80*		35.00	002
003 INIT INTERMED OFFICE VISIT					42.80*		35.00	003
004 INIT COMP OFFICE VISIT					49.90*		42.00	004
005 MINIMAL F/U OFFICE VISIT					7.00		4.00*	005
006 BRIEF F/U OFFICE VISIT					14.30*		10.00	006
007 LIMITED F/U OFFICE VISIT					15.00		4.00*	007
008 INTERMED F/U OFFICE VISIT					16.00		15.00	008
009 EXTENDED F/U OFFICE VISIT					20.00		20.00	009
010 COMPLETE F/U OFFICE VISIT					42.80*		34.20*	010
011 BRIEF F/U HOME VISIT					17.10*		14.30*	011
012 LIMITED F/U HOME VISIT					20.00		20.00	012
013 INTERMED F/U HOME VISIT					14.00		11.40*	013
014 EXTENDED CARE FACILITY VISIT					14.30		14.30*	014
015 BRIEF F/U NURSING HOME VISIT					26.50*		26.50*	015
016 INITIAL BRIEF HOSPITAL VISIT					42.80*		35.70*	016
017 INIT INTERMED HOSPITAL VISIT					50.00		50.00	017
018 INITIAL COMP HOSPITAL VISIT					14.30*		11.40*	018
019 BRIEF F/U HOSPITAL VISIT					15.00		15.00	019
020 LIMITED F/U HOSPITAL VISIT					25.00		25.00	020
021 INTERMED F/U HOSPITAL VISIT					15.00		15.00	021
022 EXTENDED F/U HOSPITAL VISIT					15.00		15.00	022
023 BRIEF EMERGENCY ROOM VISIT					30.00		30.00	023
024 LIMITED EMERGENCY ROOM VISIT					26.50*		26.50*	024
025 INTERMED EMERGENCY ROOM VISIT					49.90*		35.70*	025
026 LIMITED CONSULTATION					57.00*		49.90*	026
027 EXTENSIVE CONSULTATION					21.40*		21.40*	027
028 COMPREHENSIVE CONSULTATION					10.00		10.00	028
029 PSYCHOTHERAPY-ONE HOUR					10.00		10.00	029
030 PSYCHOTHERAPY-HALF HOUR					10.00		10.00	030
031 CHIROPRACTIC OFFICE VISIT					10.00		10.00	031
032 INITIAL PHYSIOTHERAPY					10.00		10.00	032
033 F/U PODIATRIC OFFICE VISIT					25.00		25.00	033
034 ELECTROCARDIOGRAM (EKG)					17.00		14.30*	034
035 EKG-INTERPRET. REPORT ONLY					28.00		28.00	035
036 ARTERIAL BLOOD GAS STUDY					52.50		52.50	036
037 ELECTROENCEPHALOGRAM (EEG)					10.00		7.10*	037
038 CHEMOTHERAPY					5.00		3.00	038
039 COLLECTION OF SPECIMENS					15.00		15.00	039
040 DEBRIDEMENT OF NAILS					35.00		30.00	040
041 SKIN BIOPSY					20.00		20.00	041
042 CHEMOCAUTERY					698.70*		641.70*	042
043 RADICAL MASTECTOMY					634.50*		684.50*	043
044 OPEN REDUCTION OF FRACTURE					28.50*		28.50*	044
045 ARTHROCENTESIS-MAJOR JOINT					21.40*		21.40*	045
046 ARTHROTOMY					855.60*		713.00*	046
047 ARTHROPLASTY-REPAIR OF HIP					21.40*		21.40*	047
048 NEEDLE PUNCTURE OF BURSA					149.70*		142.60*	048
049 BRONCHOSCOPY					50.00		50.00	049
050 THORACENTESIS								050

9 PREVAILING C E SUMMARY DATA METROPOLITAN LIFE INSURANCE CO. NEW YORK

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	AREA I	AREA II	AREA I	AREA II
051 CATHETERIZATION OF HEART			350.00	350.00
052 INSERTION OF PACEMAKER			800.00	600.00
053 PARTIAL COLECTOMY			798.60*	713.00*
054 APENDECTOMY			325.00	356.50*
055 SIGMOIDOSCOPY	28.50*	25.00	35.70	28.50*
056 HEMORRHOIDECTOMY			299.50*	280.00
057 COLECTECTOMY			565.00	513.40*
058 REPAIR HERNIA			356.50*	320.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY	42.80*	44.60*	42.80*	45.00
060 DILATION OF URETHRA			17.10*	20.00
061 PROSTATECTOMY			713.00*	684.50*
062 ELECTROSECTION-PROSTATE (TUR)	684.50*	684.50*	684.50*	694.50*
063 HYSTERECTOMY			698.70*	627.40*
064 INITIAL COMPLETE EYE EXAM			28.00	27.00
065 COMPREHENSIVE EYE EXAM			14.00	10.00*
066 EYE EXAM WITH TONOMETRY			684.50*	641.70*
067 EXTRACTION OF LENS	684.50*	641.70*	15.00	18.50*
068 CHEST X-RAY, SINGLE VIEW	20.00*	20.00	28.50*	25.30
069 CHEST X-RAY, TWO VIEWS	28.50*	24.00	54.00	47.00
070 X-RAY SPINE			32.50	31.00
071 X-RAY HIP			53.90*	50.90
072 X-RAY UPPER GI TRACT		65.00	55.60*	50.50
073 X-RAY COLON			13.70*	21.40*
074 RADIATION THERAPY-LOW VOLT	15.70*	21.40*	28.50*	28.50*
075 RADIATION THERAPY-SUPER VOLT	28.50*	28.50*	28.50*	28.50*
076 RADIATION THERAPY-MEGAVOLT			325.00	325.00
077 CAT SCAN - HEAD			325.00	325.00
078 CAT SCAN-HEAD, INTERPRET ONLY				
079 THREE CHEMISTRY TESTS			15.00	15.00
080 TWELVE CHEMISTRY TESTS			7.00	5.00
081 CULTURE-OTHER THAN BLOOD			4.00	3.00
082 HEMOGLOBIN			9.00	8.00
083 AUTOMATED BLOOD COUNT			3.00	3.00
084 WHITE CELL COUNT			9.00	8.00
085 COMPLETE BLOOD COUNT (CBC)			6.00	6.50
086 CHOLESTEROL TEST			3.50	3.50
087 FLOCCULATION TEST			3.00	3.00
088 HEVATOCRIT			6.25	5.00
089 PLATELET COUNT (REES-ECKER)			5.50	7.00
090 POTASSIUM TEST			5.00	5.50
091 PROTHROMBIN			4.00	4.50
092 SEDIMENTATION RATE			6.00	6.00
093 BLOOD SUGAR			6.00	7.00
094 BUN-UREA, NITROGEN			6.00	6.00
095 UPIC ACID			3.00	3.00
096 FECES-OCULT BLOOD			6.00	6.75
097 PAP TEST			4.50	4.00
098 ROUTINE URINALYSIS			2.00	2.75
099 CHEMICAL URINALYSIS			14.30*	16.00
100 PATHOLOGY-THREE SPECIMENS				

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE	LOCALITY DESIGNATION FOR SPECIALIST
001 INITIAL BRIEF OFFICE VISIT	SINGLE	SINGLE
002 INITIAL LIMITED OFFICE VISIT		25.00
003 INIT INTERMED OFFICE VISIT		
004 INIT COMP OFFICE VISIT	27.50	35.70
005 MINIMAL F/U OFFICE VISIT		
006 BRIEF F/U OFFICE VISIT		15.00
007 LIMITED F/U OFFICE VISIT	15.70	21.40
008 INTERMED F/U OFFICE VISIT		
009 EXTENDED F/U OFFICE VISIT		
010 COMPLETE F/U OFFICE VISIT		
011 BRIEF F/U HOME VISIT	17.10	21.40
012 LIMITED F/U HOME VISIT		
013 INTERMEDIATE F/U HOME VISIT		
014 EXTENDED CARE FACILITY VISIT		
015 BRIEF F/U NURSING HOME VISIT	11.40	15.00
016 INITIAL BRIEF HOSPITAL VISIT		
017 INIT INTERMED HOSPITAL VISIT		
018 INITIAL COMP HOSPITAL VISIT		
019 BRIEF F/U HOSPITAL VISIT	35.00	49.90
020 LIMITED F/U HOSPITAL VISIT	17.10	21.40
021 INTERMED F/U HOSPITAL VISIT		
022 EXTENDED F/U HOSPITAL VISIT		
023 BRIEF EMERGENCY ROOM VISIT		
024 LIMITED EMERGENCY ROOM VISIT		
025 INTERMED EMERGENCY ROOM VISIT		
026 LIMITED CONSULTATION		
027 EXTENSIVE CONSULTATION		49.90
028 COMPREHENSIVE CONSULTATION		
029 PSYCHOTHERAPY-ONE HOUR		
030 PSYCHOTHERAPY-HALF HOUR		
031 CHIROPRACTIC OFFICE VISIT		13.00
032 INITIAL PHYSIOTHERAPY		
033 F/U PODIATRIC OFFICE VISIT		14.30
034 ELECTROCARDIOGRAM (EKG)		28.50
035 EKG-INTERPRET.REPORT ONLY		14.25*
036 ARTERIAL BLOOD GAS STUDY		
037 ELECTROENCEPHALOGRAPH (EEG)		50.00
038 CHEMOTHERAPY		
039 COLLECTION OF SPECIMENS		3.00
040 DEBRIDEMENT OF NAILS		
041 SKIN BIOPSY		45.00
042 CHEMOCAUTERY		28.50
043 RADICAL MASTECTOMY		1069.50
044 OPEN REDUCTION OF FRACTURE		1140.80
045 ARTHROCENTESIS-MAJOR JOINT		20.00
046 ARTHROTOMY		25.00
047 ARTHROPLASTY-REPAIR OF HIP		1250.00
048 NEEDLE PUNCTURE OF BURSA		35.70
049 BRONCHOSCOPY		
050 THORACENTESIS	20.00	118.40

1979 PREVAILING CHARGE SUMMARY DATA GROUP HEALTH INCORPORATED

NEW YORK

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

SINGLE SINGLE

PROCEDURE DESCRIPTION

051	CATHERIZATION OF HEART				051
052	INSERTION OF PACEMAKER				052
053	RECTAL COLECTOMY				053
054	COLITOMY				054
055	SLIP COLLECTOMY	35.00			055
056	HEMIPROCTECTOMY				056
057	CHOLELITHECTOMY				057
058	REPAIR HERNIA				058
059	DIAGNOSTIC CYSTOURETHROSCOPY	64.20			059
060	DILATION OF URETHRA				060
061	PROSTATECTOMY				061
062	ELECTROSECTION-PROSTATE (TUR)	713.00			062
063	PROSTATECTOMY				063
064	COMPLETE EYE EXAM				064
065	COMPREHENSIVE EYE EXAM				065
066	EYE EXAM WITH TONOMETRY				066
067	EXTRACTION OF LENS				067
068	CHEST X-RAY, SINGLE VIEW				068
069	CHEST X-RAY, TWO VIEWS				069
070	X-RAY SPINE				070
071	X-RAY HIP				071
072	X-RAY UPPER GI TRACT				072
073	X-RAY COLON				073
074	RADIATION THERAPY-LOW VOLT				074
075	RADIATION THERAPY-SUPER VOLT				075
076	RADIATION THERAPY-NEGAVOLT				076
077	CAT SCAN - HEAD				077
078	CAT SCAN-HEAD, INTERPRET ONLY				078
079	THREE CHEMISTRY TESTS				079
080	TWELVE CHEMISTRY TESTS				080
081	CULTURE-OTHER THAN BLOOD				081
082	HEMOGLOBIN				082
083	AUTOMATED BLOOD COUNT				083
084	WHITE CELL COUNT				084
085	COMPLETE BLOOD COUNT (CBC)				085
086	CHOLESTEROL TEST				086
087	FLOCCULATION TEST				087
088	HEMATOCRIT				088
089	PLATELET COUNT (REES-ECKER)				089
090	POTASSIUM TEST				090
091	PROTHROMBIN				091
092	SEDIMENTATION RATE				092
093	BLOOD SUGAR				093
094	BUN-UREA-NITROGEN				094
095	URIC ACID				095
096	FECES-CCULT BLOOD				096
097	PAP TEST				097
098	ROUTINE URINALYSIS				098
099	CHEMICAL URINALYSIS				099
100	PATHOLOGY-THREE SPECIMENS				100

COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION

00801

001	INITIAL BRIEF OFFICE VISIT	20.00	001
002	INITIAL LIMITED OFFICE VISIT	40.00	002
003	INIT INTERMED OFFICE VISIT		003
004	INIT COMP OFFICE VISIT	63.90	004
005	MINIMAL F/U OFFICE VISIT		005
006	BRIEF F/U OFFICE VISIT	10.40	006
007	LIMITED F/U OFFICE VISIT	15.00	007
008	INTERMED F/U OFFICE VISIT	19.70	008
009	EXTENDED F/U OFFICE VISIT	40.00	009
010	COMPLETE F/U OFFICE VISIT	49.20	010
011	BRIEF F/U HOME VISIT	20.00	011
012	LIMITED F/U HOME VISIT	25.00	012
013	INTERMEDIATE F/U HOME VISIT	28.30	013
014	EXTENDED CARE FACILITY VISIT		014
015	BRIEF F/U NURSING HOME VISIT	10.40	015
016	INITIAL BRIEF HOSPITAL VISIT	30.00	016
017	INIT INTERMED HOSPITAL VISIT	49.50	017
018	INITIAL COMP HOSPITAL VISIT	64.00	018
019	BRIEF F/U HOSPITAL VISIT	10.00	019
020	LIMITED F/U HOSPITAL VISIT	15.00	020
021	INTERMED F/U HOSPITAL VISIT		021
022	EXTENDED F/U HOSPITAL VISIT	40.00	022
023	BRIEF EMERGENCY ROOM VISIT	15.00	023
024	LIMITED EMERGENCY ROOM VISIT	31.30	024
025	INTERMED EMERGENCY ROOM VISIT	52.10	025
026	LIMITED CONSULTATION	31.30	026
027	EXTENSIVE CONSULTATION	52.10	027
028	COMPREHENSIVE CONSULTATION	65.00	028
029	PSYCHOTHERAPY-ONE HOUR	63.90	029
030	PSYCHOTHERAPY-HALF HOUR	25.00	030
031	CHIROPRACTIC OFFICE VISIT	10.00	031
032	INITIAL PHYSIOTHERAPY	10.40	032
033	F/U PODIATRIC OFFICE VISIT		033
034	ELECTROCARDIOGRAM (EKG)	29.50	034
035	EKG-INTERPRET.REPORT ONLY	14.75	035
036	ARTERIAL BLOOD GAS STUDY	52.10	036
037	ELECTROENCEPHALOGRAM (EEG)	71.00	037
038	CHEMOTHERAPY	16.00	038
039	COLLECTION OF SPECIMENS	3.00	039
040	DERRIDEMENT OF NAILS	20.60	040
041	SKIN BIOPSY	29.40	041
042	CHEMOCAUTERY	32.00	042
043	RADICAL MASTECTOMY	625.60	043
044	OPEN REDUCTION OF FRACTURE	736.00	044
045	ARTHROCENTESIS-MAJOR JOINT	22.10	045
046	ARTHROTOMY	22.10	046
047	ARTHROPLASTY-REPAIR OF HIP	736.00	047
048	NEEDLE PUNCTURE OF BURSA	22.10	048
049	BRONCHOSCOPY	147.20	049
050	THORACENTESIS	36.80	050

COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION	00301	
051 CATHETERIZATION OF HEART	420.00	051
052 INSERTION OF PACEMAKER	733.00	052
053 PARTIAL COLECTOMY	662.40	053
054 APPENDECTOMY	294.40	054
055 SIGMOIDOSCOPY	35.10	055
056 HEMORRHOIDECTOMY	280.40	056
057 CHOLECYSTECTOMY	441.60	057
058 REPAIR HERNIA	257.60	058
059 DIAGNOSTIC CYSTOURETHROSCOPY	58.90	059
060 DILATION OF URETHRA	22.10	060
061 PROSTATECTOMY	560.20	061
062 ELECTROSECTION-PROSTATE (TUR)	588.80	062
063 HYSTERECTOMY	588.80	063
064 INITIAL COMPLETE EYE EXAM	30.00	064
065 COMPREHENSIVE EYE EXAM	15.00	065
066 EYE EXAM WITH TOMOMETRY	568.80	066
067 EXTRACTION OF LENS	16.80	067
068 CHEST X-RAY, SINGLE VIEW	25.30	068
069 CHEST X-RAY, TWO VIEWS	43.80	069
070 X-RAY SPINE	29.80	070
071 X-RAY HIP	87.60	071
072 X-RAY UPPER GI TRACT	52.60	072
073 X-RAY COLON	14.10	073
074 RADIATION THERAPY-LOW VOLT	21.90	074
075 RADIATION THERAPY-SUPER VOLT		075
076 RADIATION THERAPY-MEGAVOLT	135.00	076
077 CAT SCAN - HEAD		077
078 CAT SCAN-HEAD, INTERPRET ONLY	6.00	078
079 THREE CHEMISTRY TESTS	11.00	079
080 TWELVE CHEMISTRY TESTS	10.00	080
081 CULTURE-OTHER THAN BLOOD	4.20	081
082 HEMOGLOBIN		082
083 AUTOMATED BLOOD COUNT	4.20	083
084 WHITE CELL COUNT	11.20	084
085 COMPLETE BLOOD COUNT (CBC)	7.70	085
086 CHOLESTEROL TEST	4.20	086
087 FLOCCULATION TEST	4.20	087
088 HEMATOCRIT	4.20	088
089 PLATELET COUNT (REES-ECKER)	7.00	089
090 POTASSIUM TEST	7.00	090
091 PROTHROMBIN	4.20	091
092 SEDIMENTATION RATE	7.00	092
093 BLOOD SUGAR	8.40	093
094 BUN-UREA,NITROGEN	8.40	094
095 URIC ACID	2.80	095
096 FECES-OCULT BLOOD	8.00	096
097 PAP TEST	5.60	097
098 ROUTINE URINALYSIS	2.80	098
099 CHEMICAL URINALYSIS	25.00	099
100 PATHOLOGY-THREE SPECIMENS		100

PROCEDURE DESCRIPTION	COMBINED LOCALITY DESIGNATION	SINGLE
001 INITIAL BRIEF OFFICE VISIT	11.70	001
002 INITIAL LIMITED OFFICE VISIT	11.70	002
003 INIT INTERMED OFFICE VISIT	20.00	003
004 INIT COMP OFFICE VISIT	35.00	004
005 MINIMAL F/U OFFICE VISIT	11.40*	005
006 BRIEF F/U OFFICE VISIT	11.40*	006
007 LIMITED F/U OFFICE VISIT	11.40*	007
008 INTERMED F/U OFFICE VISIT	14.30*	008
009 EXTENDED F/U OFFICE VISIT	21.40*	009
010 COMPLETE F/U OFFICE VISIT	42.80*	010
011 BRIEF F/U HOME VISIT	14.30	011
012 LIMITED F/U HOME VISIT	14.30	012
013 INTERMEDIATE F/U HOME VISIT	20.00	013
014 EXTENDED CARE FACILITY VISIT	14.30*	014
015 BRIEF F/U NURSING HOME VISIT	14.30*	015
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	016
017 INIT INTERMED HOSPITAL VISIT	28.50*	017
018 INITIAL COMP HOSPITAL VISIT	28.50*	018
019 BRIEF F/U HOSPITAL VISIT	11.40*	019
020 LIMITED F/U HOSPITAL VISIT	11.40*	020
021 INTERMED F/U HOSPITAL VISIT	19.95*	021
022 EXTENDED F/U HOSPITAL VISIT	19.95*	022
023 BRIEF EMERGENCY ROOM VISIT	20.00*	023
024 LIMITED EMERGENCY ROOM VISIT	20.00*	024
025 INTERMED EMERGENCY ROOM VISIT	20.00*	025
026 LIMITED CONSULTATION	34.20	026
027 EXTENSIVE CONSULTATION	68.40	027
028 COMPREHENSIVE CONSULTATION	68.40	028
029 PSYCHOTHERAPY-ONE HOUR	45.60	029
030 PSYCHOTHERAPY-HALF HOUR	28.50	030
031 CHIROPRACTIC OFFICE VISIT	11.40*	031
032 INITIAL PHYSIOTHERAPY	12.60	032
033 F/U PODIATRIC OFFICE VISIT	14.30*	033
034 ELECTROCARDIOGRAM (EKG)	24.00	034
035 EKG-INTERPRET-REPORT ONLY		035
036 ARTERIAL BLOOD GAS STUDY		036
037 ELECTROENCEPHALOGRAPH (EEG)	65.00	037
038 CHEMOTHERAPY	14.30*	038
039 COLLECTION OF SPECIMENS		039
040 DEBRIDEMENT OF NAILS	14.30*	040
041 SKIN BIOPSY	25.80*	041
042 CHEMOCAUTERY	25.80*	042
043 RADICAL MASTECTOMY	627.50*	043
044 OPEN REDUCTION OF FRACTURE	733.60*	044
045 ARTHROCENTESIS-MAJOR JOINT		045
046 ARTHROTOMY		046
047 ARTHROPLASTY-REPAIR OF HIP	15.00*	047
048 NEEDLE PUNCTURE OF BURSA	1075.00*	048
049 BRONCHOSCOPY	14.30	049
050 THORACENTESIS	129.00*	050
	49.90	

079 PREVAILING CHARGE SUMMARY DATA GENESSEE VALLEY MEDICAL CARE NEW YORK COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION	SINGLE
051 CATHETERIZATION OF HEART	322.50*
052 INSERTION OF PACEMAKER	860.00*
053 PARTIAL COLECTOMY	688.00*
054 APPENDECTOMY	201.00*
055 SIGMOIDOSCOPY	25.00*
056 MEYERROTHIDECTOMY	197.80*
057 CHOLECYSTECTOMY	473.00*
058 REPAIR HERNIA	283.80*
059 DIAGNOSTIC CYSTOURETHROSCOPY	51.60*
060 DILATION OF URETHRA	12.00
061 PROSTATECTOMY	645.00*
062 ELECTROSECTION-PROSTATE (TUR)	645.00*
063 HYSTERECTOMY	593.40*
064 INITIAL COMPLETE EYE EXAM	21.00
065 COMPREHENSIVE EYE EXAM	12.60
066 EYE EXAM WITH TONOMETRY	645.00*
067 EXTRACTION OF LENS	21.17*
068 CHEST X-RAY, SINGLE VIEW	30.80*
069 CHEST X-RAY, TWO VIEWS	30.80*
070 X-RAY SPINE	40.42*
071 X-RAY HIP	71.22*
072 X-RAY UPPER GI TRACT	71.22*
073 X-RAY COLON	19.25*
074 RADIATION THERAPY-LOW VOLT	50.05*
075 RADIATION THERAPY-SUPER VOLT	46.20*
076 RADIATION THERAPY-MEGAVOLT	250.00*
077 CAT SCAN - HEAD	65.00
078 CAT SCAN-HEAD, INTERPRET ONLY	
079 THREE CHEMISTRY TESTS	
080 TWELVE CHEMISTRY TESTS	9.00
081 CULTURE-OTHER THAN BLOOD	3.70
082 HEMOGLOBIN	6.10
083 ANCHORED BLOOD COUNT	3.00
084 WHITE CELL COUNT	6.10
085 COMPLETE BLOOD COUNT (CBC)	5.05
086 CHOLESTEROL TEST	21.00*
087 FLOCCULATION TEST	3.00
088 HEYATOCRIT	5.00
089 PLATELET COUNT (REES-ECKER)	4.50
090 POTASSIUM TEST	4.50
091 PROTHROMBIN	4.00
092 SEDIMENTATION RATE	5.00
093 BLOOD SUGAR	5.20
094 BUN-UREA, NITROGEN	6.00
095 URIC ACID	3.20
096 FECES-OCCULT BLOOD	5.50
097 PAP TEST	5.00
098 ROUTINE URINALYSIS	5.00
099 CHEMICAL URINALYSIS	20.20
100 PATHOLOGY-THREE SPECIMENS	

NORTH CAROLINA

NORTH CAROLINA

GREENSBORO 94

DURHAM 94

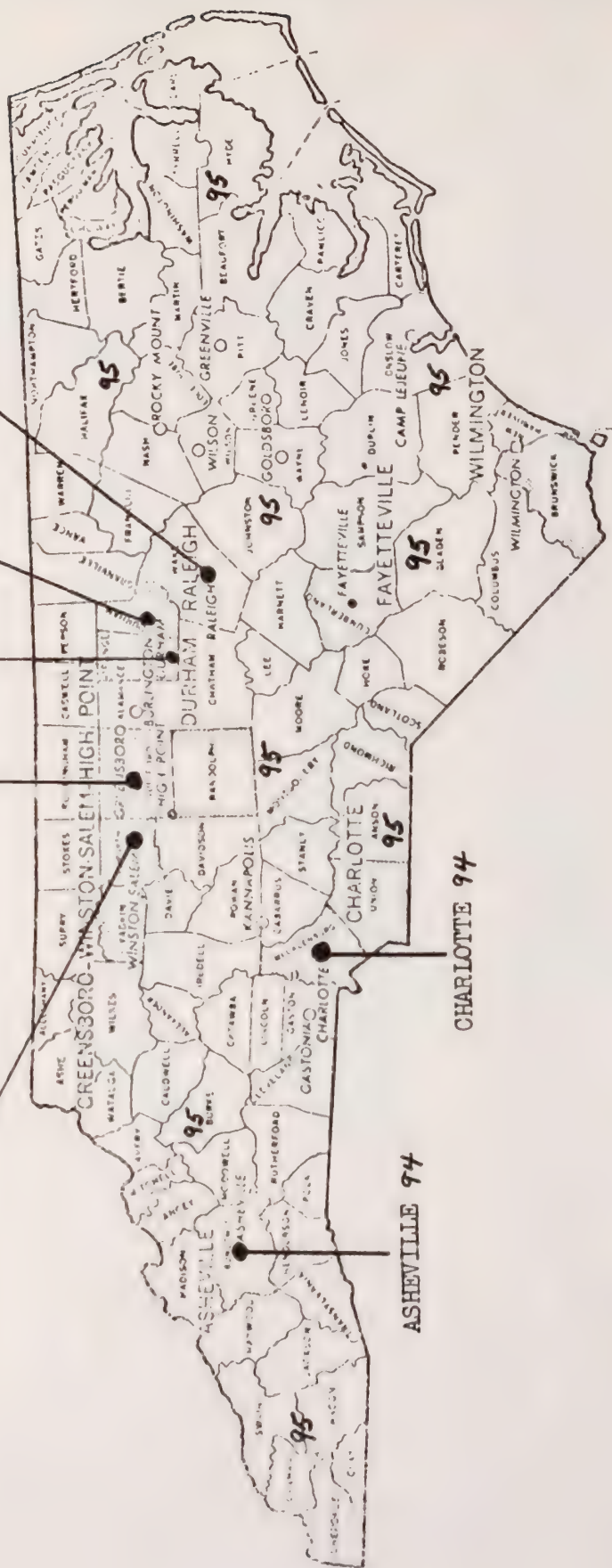
RALEIGH 94

CHAPEL HILL 94

WINSTON-SALEM 94

CHARLOTTE 94

ASHEVILLE 94



Two Localities:

Area 94, - Charlotte, Durham, Greensboro, Winston-Salem, Raleigh,

Asheville, Chapel Hill. (Locality determined by the
city cited in the return address.)

Area 95. - All other cities not listed above and all rural areas.

1979 PREVAILING CHARGE SUMMARY DATA

NORTH CAROLINA

PRUDENTIAL INSURANCE COMPANY

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

94

95

94

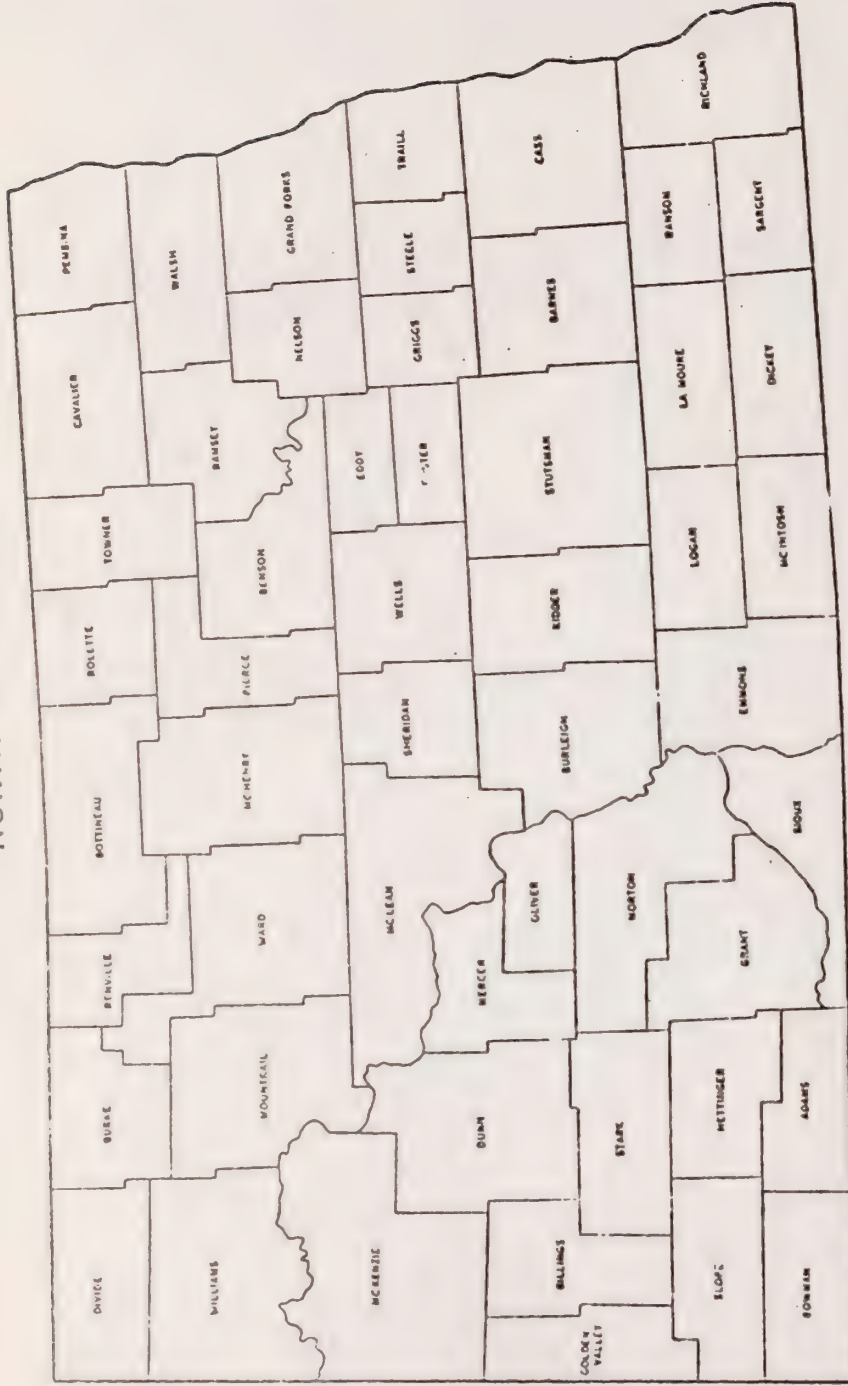
95

001 INITIAL BRIEF OFFICE VISIT				001
002 INITIAL LIMITED OFFICE VISIT				002
003 INIT INTERMED OFFICE VISIT				003
004 INIT COMP OFFICE VISIT				004
005 MINIMAL F/U OFFICE VISIT				005
006 BRIEF F/U OFFICE VISIT				006
007 LIMITED F/U OFFICE VISIT				007
008 INTERMED F/U OFFICE VISIT				008
009 EXTENDED F/U OFFICE VISIT				009
010 COMPLETE F/U OFFICE VISIT				010
011 BRIEF F/U HOME VISIT				011
012 LIMITED F/U HOME VISIT				012
013 INTERMEDIATE F/U HOME VISIT				013
014 EXTENDED CARE FACILITY VISIT				014
015 BRIEF F/U NURSING HOME VISIT				015
016 INITIAL BRIEF HOSPITAL VISIT				016
017 INIT INTERMED HOSPITAL VISIT				017
018 INITIAL COMP HOSPITAL VISIT				018
019 BRIEF F/U HOSPITAL VISIT				019
020 LIMITED F/U HOSPITAL VISIT				020
021 INTERMED F/U HOSPITAL VISIT				021
022 EXTENDED F/U HOSPITAL VISIT				022
023 BRIEF EMERGENCY ROOM VISIT				023
024 LIMITED EMERGENCY ROOM VISIT				024
025 INTERMED EMERGENCY ROOM VISIT				025
026 LIMITED CONSULTATION				026
027 EXTENSIVE CONSULTATION				027
028 COMPREHENSIVE CONSULTATION				028
029 PSYCHOTHERAPY-ONE HOUR				029
030 PSYCHOTHERAPY-HALF HOUR				030
031 CHIROPRACTIC OFFICE VISIT				031
032 INITIAL PHYSICIAN VISIT				032
033 F/U PEDIATRIC OFFICE VISIT				033
034 ELECTROCARDIOGRAM (ECG)				034
035 EKG-INTERPRET. REPORT ONLY				035
036 ARTERIAL BLOOD GAS STUDY				036
037 ELECTROENCEPHALOGRAPH (EEG)				037
038 CHEMOTHERAPY				038
039 COLLECTION OF SPECIMENS				039
040 DEBRIDEMENT OF NAILS				040
041 SKIN BIOPSY				041
042 CHEMOCAUTERY				042
043 RADICAL MASTECTOMY				043
044 OPEN REDUCTION OF FRACTURE				044
045 ART. ANTHESIS-MAJOR JOINT				045
046 ARTHROPLASTY				046
047 ARTHROPLASTY-REPAIR OF				047
048 NEEDLE PUNCTURE OF BURSA				048
049 ENDOSCOPIC				049
050 THORACENTESIS				050

DESCRIPTION	94	95	96
051 CATHETERIZATION OF HEART	300.00		300.00
052 INSERTION OF PACEMAKER	1000.00		855.60*
053 PARTIAL COLECTOMY	800.00		684.50*
054 APENDECTOMY	370.80*		356.50*
055 SALpingECTOMY	30.00	21.40*	28.50*
056 HEMORRHOIDECTOMY	350.00		256.70*
057 COLECTECTOMY	550.00		510.00
058 REPAIR HERNIA	356.50*		299.50*
059 DIAGNOSTIC CYSTOURETHROSCOPY	42.80*	36.00*	42.80*
060 DILATION OF URETHRA	15.00*		15.00*
061 PROSTATECTOMY	720.00		720.00
062 ELECTROSECTION-PROSTATE (TURP)	720.00	720.00	720.00
063 HYSTERECTION	640.00		598.90
064 INITIAL COMPLETE EYE EXAM	22.00		22.00
065 COMPREHENSIVE EYE EXAM			
066 EYE EXAM WITH TOMOMETRY			
067 EXTRACTION OF LENS	641.70*	641.70*	641.70*
068 CHEST X-RAY, SINGLE VIEW	17.00	14.30*	17.00
069 CHEST X-RAY, TWO VIEWS	20.00	20.00	21.40*
070 X-RAY SPINE			35.70*
071 X-RAY HIP			21.40*
072 X-RAY UPPER GI TRACT	42.80*	45.90*	42.80*
073 X-RAY COLON			21.40*
074 RADIATION THERAPY-LOW VOLT			42.80*
075 RADIATION THERAPY-SUPER VOLT	18.10*	18.10*	19.10*
076 RADIATION THERAPY-NEGAVOLT	19.90*	19.90*	25.00*
077 CAT SCAN - HEAD			
078 CAT SCAN-HEAD, INTERPRET ONLY	150.00	150.00	150.00
079 THREE CHEMISTRY TESTS	50.00	50.00	50.00
080 TWELVE CHEMISTRY TESTS	15.75	15.75	15.75
081 CULTURE-OTHER THAN BLOOD	10.60	10.60	10.60
082 HEMOGLOBIN	11.00	11.00	10.00
083 ALCOHOL BLOOD COUNT	3.00	3.00	3.00
084 WHITE CELL COUNT			
085 COMPLETE BLOOD COUNT (CBC)	3.00	3.00	3.00
086 CHOLESTEROL TEST	8.30	8.30	8.30
087 FLOCCULATION TEST	7.00	7.00	7.00
088 HEMATOCCRIT	5.00	5.00	4.00
089 PLATELET COUNT (REES-ECKER)	3.00	3.00	3.00
090 POTASSIUM TEST	7.00	7.00	5.00
091 PROTHROMBIN	7.50	7.50	6.00
092 CALCULATION RATE	7.00	7.00	5.00
093 BUN, CREATININ, URIC ACID	5.00	5.00	5.00
094 URIC ACID	6.00	6.00	6.00
095 FECES-OCCULT BLOOD	6.00	6.00	7.00
096 PAP TEST	3.00	3.00	3.00
097 ROUTINE URINALYSIS	8.00	8.00	8.00
098 CHEMICAL URINALYSIS	4.20	4.20	3.00
099 PATHOLOGY-THREE SPECIMENS	2.50	2.50	2.50
100	20.00	20.00	20.00

NORTH DAKOTA

NORTH DAKOTA



One Locality - Statewide

COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION

820

001	INITIAL BRIEF OFFICE VISIT	14.30*	001
002	INITIAL LIMITED OFFICE VISIT	28.50*	002
003	INIT INTERMED OFFICE VISIT	28.50*	003
004	INIT COMP OFFICE VISIT	46.30*	004
005	MINIMAL F/U OFFICE VISIT	7.10*	005
006	BRIEF F/U OFFICE VISIT	8.60*	006
007	LIMITED F/U OFFICE VISIT	12.90*	007
008	INTERMED F/U OFFICE VISIT	14.30*	008
009	EXTENDED F/U OFFICE VISIT	25.70*	009
010	COMPLETE F/U OFFICE VISIT	35.60*	010
011	BRIEF F/U HOME VISIT	15.10*	011
012	LIMITED F/U HOME VISIT	15.00	012
013	INTERMEDIATE F/U HOME VISIT	15.00	013
014	EXTENDED CARE FACILITY VISIT	8.20	014
015	BRIEF F/U NURSING HOME VISIT	8.60*	015
016	INITIAL BRIEF HOSPITAL VISIT	34.20*	016
017	INIT INTERMED HOSPITAL VISIT	46.30*	017
018	INITIAL COMP HOSPITAL VISIT	68.50*	018
019	BRIEF F/U HOSPITAL VISIT	8.60*	019
020	LIMITED F/U HOSPITAL VISIT	17.10*	020
021	INTERMED F/U HOSPITAL VISIT	34.20*	021
022	EXTENDED F/U HOSPITAL VISIT	15.10*	022
023	BRIEF EMERGENCY ROOM VISIT	24.40*	023
024	LIMITED EMERGENCY ROOM VISIT	24.40*	024
025	INTERMED EMERGENCY ROOM VISIT	25.70*	025
026	LIMITED CONSULTATION	45.00	026
027	EXTENSIVE CONSULTATION	64.10*	027
028	COMPREHENSIVE CONSULTATION	10.80*	028
029	PSYCHOTHERAPY-ONE HOUR	10.80*	029
030	PSYCHOTHERAPY-HALF HOUR	10.80*	030
031	CHIROPRACTIC OFFICE VISIT	15.70*	031
032	INITIAL PHYSIOTHERAPY	15.70*	032
033	F/U PODIATRIC OFFICE VISIT	25.50*	033
034	EKG-INTERPRET, REPORT ONLY	12.50*	034
035	ARTERIAL BLOOD GAS STUDY	35.20	035
036	ELECTROENCEPHALOGRAPH (EEG)	57.20*	036
037	CHEMOTHERAPY	13.00*	037
038	COLLECTION OF SPECIMENS	3.00	038
039	DEBRIDEMENT OF NAILS	13.50*	039
040	SKIN BIOPSY	25.70*	040
041	CHEMOCAUTERY	17.10*	041
042	RADICAL MASTECTOMY	598.90*	042
043	OPEN REDUCTION OF FRACTURE	684.50*	043
044	ARTHROCENTESIS-MAJOR JOINT	28.50*	044
045	ARTHROTOMY	18.60*	045
046	ARTHROPLASTY-REPAIR OF HIP	17.10*	046
047	NEEDLE PUNCTURE OF BURSA	142.60*	047
048	BRONCHOSCOPY	25.70*	048
049	THORACENTESIS		049
050			050

COMBINED LOCALITY DESIGNATION

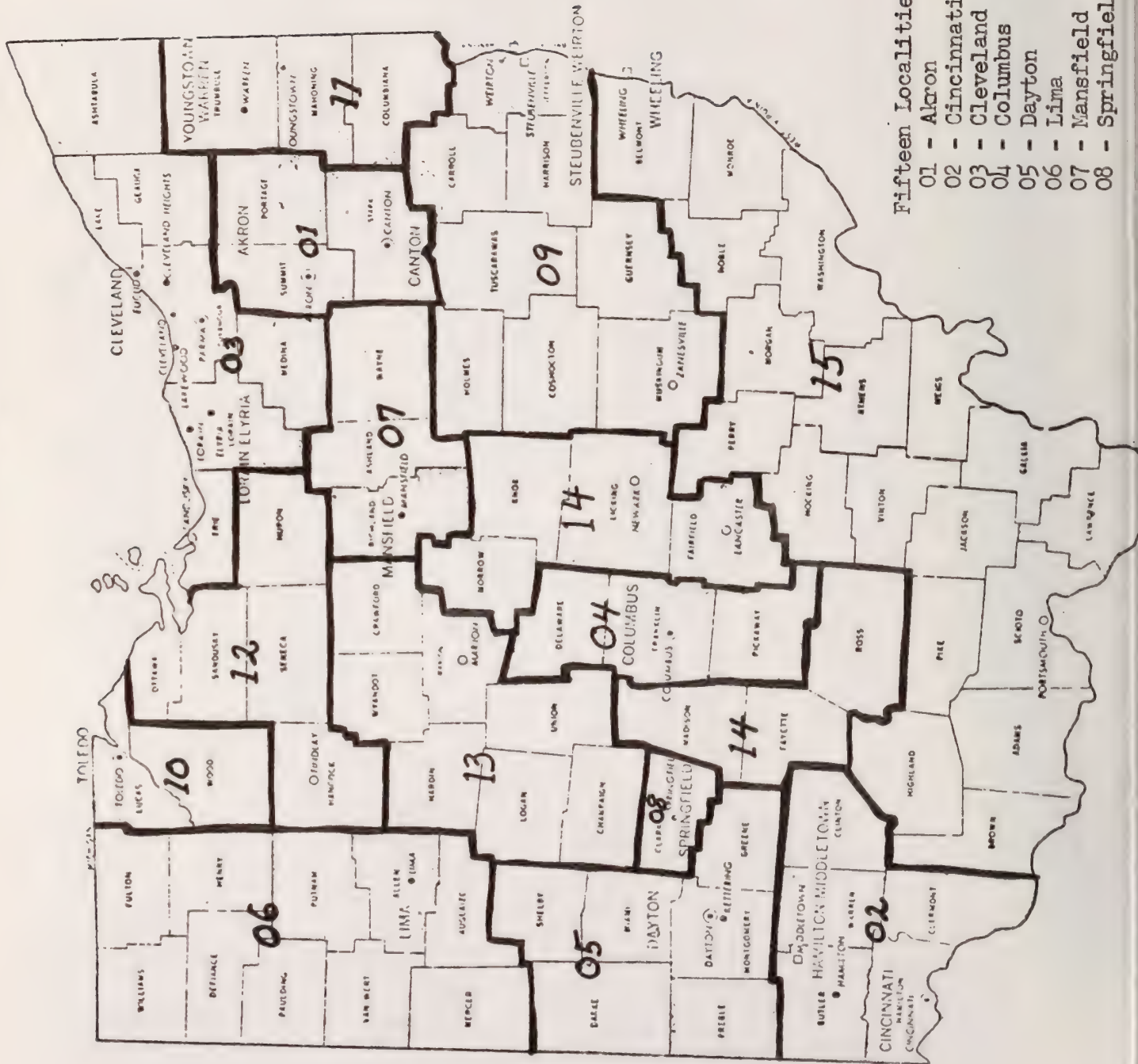
PROCEDURE DESCRIPTION

820

051	CATHETERIZATION OF HEART	792.90*	051
052	INSERTION OF PACEMAKER	634.50*	052
053	PARTIAL COLECTOMY	320.00*	053
054	APPENDECTOMY	25.70*	054
055	SIGMOIDOSCOPY	256.70*	055
056	PERYRN-OIDECTOMY	513.40*	056
057	CHOLECYSTECTOMY	313.70*	057
058	REPAIR HERNIA	42.80*	058
059	DIAGNOSTIC CYSTOURETHROSCOPY	25.70*	059
060	DILATION OF URETHRA	684.50*	060
061	PROSTATECTOMY	684.50*	061
062	ELECTROSECTION-PROSTATE (TUR)	598.90*	062
063	HYSTERECTOMY		063
064	INITIAL COMPLETE EYE EXAM	641.70*	064
065	COMPREHENSIVE EYE EXAM	15.70*	065
066	EYE EXAM WITH TONOMETRY	25.70*	066
067	EXTRACTION OF LENS	23.50*	067
068	CHEST X-RAY, SINGLE VIEW	28.50*	068
069	CHEST X-RAY, TWO VIEWS	55.70*	069
070	X-RAY SPINE	45.60*	070
071	X-RAY HIP	22.90	071
072	X-RAY UPPER GI TRACT		072
073	X-RAY COLON		073
074	RADIATION THERAPY-LOW VOLT		074
075	RADIATION THERAPY-SUPER VOLT		075
076	RADIATION THERAPY-MEGAVOLT		076
077	CAT SCAN - HEAD		077
078	CAT SCAN-HEAD, INTERPRET ONLY		078
079	THREE CHEMISTRY TESTS		079
080	TWELVE CHEMISTRY TESTS	21.00	080
081	CULTURE-OTHER THAN BLOOD	8.50	081
082	HEMOGLOBIN	4.00	082
083	AUTCLATED BLOOD COUNT	8.75	083
084	WHITE CELL COUNT	4.00	084
085	COMPLETE BLOOD COUNT (CBC)	12.50	085
086	CHOLESTEROL TEST	8.00	086
087	FLOCCULATION TEST	4.25	087
088	HEMATOCRIT	4.00	088
089	PLATELET COUNT (REES-ECKER)	5.25	089
090	POTASSIUM TEST	9.00	090
091	PROTHROMBIN	7.00	091
092	SEDIMENTATION RATE	5.00	092
093	BLOOD SUGAR	8.00	093
094	BUN-UREA, NITROGEN	8.40	094
095	URIC ACID	8.50	095
096	FECES-OCCULT BLOOD	3.00	096
097	PAP TEST	8.25	097
098	ROUTINE URINALYSIS	4.40	098
099	CHEMICAL URINALYSIS	2.70	099
100	PATHOLOGY-THREE SPECIMENS	18.00	100

OHIO

OHIO



Fifteen Localities:

- | | |
|------------------|----------------------|
| 01 - Akron | 09 - Steubenville |
| 02 - Cincinnati | 10 - Toledo |
| 03 - Cleveland | 11 - Youngstown |
| 04 - Columbus | 12 - Lake Plains |
| 05 - Dayton | 13 - Sandusky Valley |
| 06 - Lima | 14 - Scioto Valley |
| 07 - Mansfield | 15 - Ohio Valley |
| 08 - Springfield | |

1979 PREVAILING CHARGE SUMMARY DATA

OHIO

NATIONWIDE MUTUAL INSURANCE CO.

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	04	05	01	02	03	04	05
001 INITIAL BRIEF OFFICE VISIT	17.10*	18.00	15.00	15.00*	15.00*	14.30*	12.80*	14.30*	14.30*	14.30*
002 INITIAL LIMITED OFFICE VISIT	49.90*	45.60*	45.00	35.00	49.90*	20.00	21.40*	15.00*	20.00	20.00
003 INIT INTERMED OFFICE VISIT	14.30*	11.40*	14.00	14.00	11.40*	49.90*	49.90*	49.90*	49.90*	49.90*
004 INIT COMP OFFICE VISIT	11.40*	10.00*	10.00*	10.00*	10.00*	10.00	14.30*	14.30*	14.30*	14.30*
005 MINIMAL F/U OFFICE VISIT	17.10*	18.00*	15.00	15.00*	15.00*	20.00	21.40*	15.00*	20.00	20.00
006 BRIEF F/U OFFICE VISIT	17.10*	18.00*	15.00	15.00*	15.00*	49.90	49.90*	49.90*	49.90*	49.90*
007 LIMITED F/U OFFICE VISIT	49.90*	45.60*	45.00	35.00*	49.90*	49.90	49.90*	49.90*	49.90*	49.90*
008 INTERMED F/U OFFICE VISIT	49.90*	45.60*	45.00	35.00*	49.90*	49.90	49.90*	49.90*	49.90*	49.90*
009 EXTENDED F/U OFFICE VISIT	49.90*	45.60*	45.00	35.00*	49.90*	49.90	49.90*	49.90*	49.90*	49.90*
010 COMPLETE F/U OFFICE VISIT	17.10*	14.30*	17.10*	15.00	14.30*	17.10*	20.00	15.00	17.10*	15.00
011 BRIEF F/U HOME VISIT	17.10*	14.30*	17.10*	15.00	14.30*	17.10*	20.00	15.00	17.10*	15.00
012 LIMITED F/U HOME VISIT	17.10*	14.30*	17.10*	15.00	14.30*	17.10*	20.00	15.00	17.10*	15.00
013 INTERMED F/U HOME VISIT	11.40*	10.00	10.00	10.00	10.00	13.00	12.80*	14.30*	14.30*	14.30*
014 EXTENDED CARE FACILITY VISIT	21.40*	21.40*	28.50*	25.00	28.50*	35.00	35.00	35.70*	35.70*	40.00
015 BRIEF F/U NURSING HOME VISIT	42.80*	49.90*	35.00	50.00	49.90*	42.80*	49.90*	42.80*	42.80*	60.00
016 INITIAL BRIEF HOSPITAL VISIT	12.80*	11.40*	11.40*	12.50	14.30*	49.90*	57.00*	45.00	50.00	65.00
017 INIT INTERMED HOSPITAL VISIT	21.40*	21.40*	28.50*	25.00	28.50*	14.30*	14.30*	14.30*	14.30*	15.00
018 INITIAL COMP HOSPITAL VISIT	21.40*	21.40*	28.50*	25.00	28.50*	35.00	35.00	35.70*	35.70*	40.00
019 BRIEF F/U HOSPITAL VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
020 LIMITED F/U HOSPITAL VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
021 INTERMED F/U HOSPITAL VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
022 EXTENDED F/U HOSPITAL VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
023 BRIEF EMERGENCY ROOM VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
024 LIMITED EMERGENCY ROOM VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
025 INTERMED EMERGENCY ROOM VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
026 LIMITED CONSULTATION	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
027 EXTENSIVE CONSULTATION	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
028 COMPREHENSIVE CONSULTATION	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
029 PSYCHOTHERAPY-CNE HOUR	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
030 PSYCHOTHERAPY-HALF HOUR	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
031 CHIROPRACTIC OFFICE VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
032 INITIAL PHYSIOTHERAPY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
033 F/U PODIATRIC OFFICE VISIT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
034 ELECTROCARDIOGRAM (EKG)	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
035 EKG-INTERPRET, REPORT ONLY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
036 ARTERIAL BLOOD GAS STUDY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
037 ELECTROENCEPHALOGRAM (EEG)	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
038 CHEMOTHERAPY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
039 COLLECTION OF SPECIMENS	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
040 DEBRIDEMENT OF NAILS	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
041 SKIN BIOPSY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
042 CHEMOCAUTERY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
043 RADICAL MASTECTOMY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
044 OPEN REDUCTION OF FRACTURE	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
045 ARTHROCENTESIS-MAJOR JOINT	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
046 ARTHROTOMY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
047 ARTHROPLASTY-REPAIR OF HIP	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
048 NEEDLE PUNCTURE OF BURSA	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
049 BRONCHOSCOPY	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00
050 THORACENTESIS	35.00	49.90*	49.90*	49.90*	28.50*	35.00	35.00	35.70*	35.70*	40.00

1979 PREVAILING CHARGE SUMMARY DATA

OHIO

NATIONWIDE MUTUAL INSURANCE CO.

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	04	05	01	02	03	04	05
051 CATHETERIZATION OF HEART						427.80*	427.80*	427.80*	427.80*	427.80*
052 INSERTION OF PACEMAKER						713.00*	845.00*	845.00*	845.00*	845.00*
053 PARTIAL COLECTOMY						713.00*	825.00	784.30*	759.00	713.00*
054 APPENDECTOMY						356.50*	356.50*	356.50*	356.50*	356.50*
055 Sigmoidoscopy	28.50*	25.00	35.00	25.00*	21.40*	35.00	30.00	35.00	28.50*	30.00
056 HEMORRHOIDECTOMY						350.00	356.50*	330.00	356.50*	350.00
057 CHOLECYSTECTOMY						570.40*	570.40*	570.40*	570.40*	499.10*
058 REPAIR HERNIA						356.50*	356.50*	356.50*	320.90*	320.90*
059 DIAGNOSTIC CYSTOSCOPIC SURGERY	45.00	45.00*	45.00	45.00	45.00	49.90*	49.90*	65.00	49.90*	40.00
060 DILATION OF URETHRA						14.30*	14.30*	20.00	21.40*	14.30*
061 SPOTECTOMY						641.70*	713.00*	713.00*	640.00	741.50*
062 ELECTROSESECTION-PROSTATE (TURP)	499.10*	499.10*	664.10*	499.10*	499.10*	641.70*	641.70*	641.70*	641.70*	741.50*
063 HYSTERECTOMY						641.70*	641.70*	641.70*	641.70*	641.70*
064 INITIAL COMPLETE EYE EXAM						22.80*	22.80*	25.00	25.00	22.40*
065 COMPREHENSIVE EYE EXAM						22.80*	22.80*	25.00	25.00	22.40*
066 EYE EXAM WITH TONOMETRY						14.30*	15.00	15.00	14.30*	14.30*
067 EXTRACTION OF LENS	570.40*	713.00*	675.00*	606.10*	570.40*	570.40*	713.00*	700.00	606.10*	570.40*
068 CHEST X-RAY, SINGLE VIEW	15.00*	17.10*	15.00*	15.00	17.10*	18.00*	16.00	15.00*	17.10*	15.00*
069 CHEST X-RAY, TWO VIEWS	21.40*	21.00	21.00	21.40*	21.40*	22.00	22.00	25.70*	21.40*	20.00
070 X-RAY SPINE						34.50	39.00	42.80*	41.00	40.00
071 X-RAY HIP						22.00	20.00	35.70*	21.40*	25.00
072 X-RAY UPPER GI TRACT	35.70*	42.00	35.70*	35.70*	35.70*	47.00	42.80*	44.00*	45.00	40.00
073 X-RAY COLON						35.00*	42.80*	49.90*	42.80*	42.80*
074 RADIATION THERAPY-LOW VOLT	17.50*	20.00	15.00	20.00	18.00	17.50*	25.00	17.80*	21.40*	21.40*
075 RADIATION THERAPY-SUPER VOLT	35.70*	28.50	23.70	21.40*	18.00	35.70*	28.50*	23.70*	21.40*	21.40*
076 RADIATION THERAPY-MEGAVOLT						27.00	25.00	27.00	22.00	28.00
077 CAT SCAN - HEAD						148.30*	150.00*	150.00*	150.00*	150.00*
078 CAT SCAN-HEAD, INTERPRET ONLY										
079 THREE CHEMISTRY TESTS						1.30	1.70	1.40	1.30	2.00
080 TWELVE CHEMISTRY TESTS						9.00	8.00	12.50	12.00	15.00
081 CULTURE-OTHER THAN BLOOD						3.00	3.00	3.00	2.00	5.00
082 REVOCULOSIN										
083 AUTOMATED BLOOD COUNT						3.00	4.00	3.50	3.00	4.00
084 WHITE CELL COUNT						9.50	9.75	8.00	7.00	9.75
085 COMPLETE BLOOD COUNT (CBC)						7.00	7.00	6.00	5.50	7.00
086 CHOLESTEROL TEST						5.50	7.50	4.50	3.00	7.00
087 FLOCCULATION TEST						3.50	4.00	3.00	3.00	6.00
088 HEMATOGRIT						5.00	7.00	6.00	6.40	6.00
089 PLATELET COUNT (REES-ECKER)						7.00	7.75	6.00	5.75	7.00
090 POTASSIUM TEST						6.00	6.25	6.00	5.00	7.50
091 PROTHROMBIN						4.50	6.00	5.00	3.50	5.00
092 SEDIMENTATION RATE						6.00	7.25	6.00	5.75	7.00
093 BLOOD SUGAR						7.00	8.00	5.00	5.00	7.00
094 BUN-URIC-NITROGEN						7.00	7.00	5.50	5.00	8.00
095 URIC ACID						3.00	3.00	3.00	2.00	3.00
096 FECES-OCULT BLOOD						8.00	10.00	8.00	7.00	8.00
097 PAP TEST						5.00	5.00	5.00	4.50	5.00
098 ROUTINE URINALYSIS						4.00	5.00	3.75	3.00	2.60
099 CHEMICAL URINALYSIS										
100 PATHOLOGY-THREE SPECIMENS						16.00	15.00	18.00	12.00	15.00

1979 PREVAILING CHARGE SUMMARY DATA

NATIONWIDE MUTUAL INSURANCE CO.

OHIO

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

06

07

08

09

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06

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001 INITIAL BRIEF OFFICE VISIT
002 INITIAL LIMITED OFFICE VISIT
003 INIT INTERMED OFFICE VISIT
004 INIT COMP OFFICE VISIT
005 MINIMAL F/U OFFICE VISIT
006 BRIEF F/U OFFICE VISIT
007 LIMITED F/U OFFICE VISIT
008 INTERMED F/U OFFICE VISIT
009 EXTENDED F/U OFFICE VISIT
010 COMPLETE F/U OFFICE VISIT
011 BRIEF F/U HOME VISIT
012 LIMITED F/U HOME VISIT
013 INTERMEDIATE F/U HOME VISIT
014 EXTENDED CARE FACILITY VISIT
015 BRIEF F/U NURSING HOME VISIT
016 INITIAL BRIEF HOSPITAL VISIT
017 INIT INTERMED HOSPITAL VISIT
018 INITIAL COMP HOSPITAL VISIT
019 BRIEF F/U HOSPITAL VISIT
020 LIMITED F/U HOSPITAL VISIT
021 INTERMED F/U HOSPITAL VISIT
022 EXTENDED F/U HOSPITAL VISIT
023 BRIEF EMERGENCY ROOM VISIT
024 LIMITED EMERGENCY ROOM VISIT
025 INTERMED EMERGENCY ROOM VISIT
026 LIMITED CONSULTATION
027 EXTENSIVE CONSULTATION
028 COMPREHENSIVE CONSULTATION
029 PSYCHOTHERAPY-ONE HOUR
030 PSYCHOTHERAPY-HALF HOUR
031 CHIROPRACTIC OFFICE VISIT
032 INITIAL PHYSIOTHERAPY
033 F/U PODIATRIC OFFICE VISIT
034 ELECTROCARDIOGRAM (EKG)
035 EKG-INTERPRET, REPORT ONLY
036 ARTERIAL BLOOD GAS STUDY
037 ELECTROENCEPHALOGRAM (EEG)
038 CHEMOTHERAPY
039 COLLECTION OF SPECIMENS
040 DEBRIDEMENT OF NAILS
041 SKIN BIOPSY
042 CHEMOCAUTERY
043 RADICAL MASTECTOMY
044 OPEN REDUCTION OF FRACTURE
045 ARTHROCENTESIS-MAJOR JOINT
046 ARTHROTOMY
047 ARTHROPLASTY-REPAIR OF HIP
048 NEEDLE PUNCTURE OF BURSA
049 BRONCHOSCOPY
050 THORACENTESIS

14.30* 14.30* 15.00 20.00 20.00 10.00* 11.40* 11.00 14.30* 001
30.00 32.00 25.00 40.00 28.50* 20.00 16.00 15.00* 21.40* 002
11.40* 11.00 11.40* 12.80* 10.00 42.80* 21.40 21.40* 21.40* 003
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14.30* 14.30* 15.00 20.00 20.00 20.00 16.00 11.40* 14.30* 006
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14.30* 12.00 16.00 17.10* 12.00 15.00 15.00 20.00 17.10* 008
14.30* 12.00 16.00 17.10* 12.00 15.00 15.00 20.00 17.10* 009
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22.80* 21.40* 25.00 21.40* 21.40* 21.40* 21.40* 21.40* 21.40* 011
35.70* 35.70* 40.00 35.00 35.70* 42.80* 42.80* 42.80* 35.70* 012
8.60* 10.00* 10.00* 11.40* 8.60* 11.40* 11.40* 11.40* 11.40* 013
22.80* 21.40* 25.00 21.40* 21.40* 21.40* 21.40* 21.40* 21.40* 014
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14.30* 14.30* 15.00 15.00 15.00 15.00 15.00 15.00 15.00 020
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1979 PREVAILING CHARGE SUMMARY DATA

OHIO

NATIONWIDE MUTUAL INSURANCE CO.

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	06	07	08	09	10	06	07	08	09	10
051 CATHETERIZATION OF HEART						427.80*	427.80*	427.80*	427.80*	427.80*
052 INSERTION OF PACEMAKER						845.00	845.00	845.00	845.00	855.60*
053 PARTIAL COLECTOMY						750.00	713.00*	600.00	606.10*	713.00*
054 APPENDECTOMY						350.80*	356.50*	356.50*	356.50*	356.50*
055 STONIOSCOPY	32.00	33.00	28.50*	20.00	25.00	45.00	35.00	30.00	28.50*	35.00
056 HEMORRHOIDECTOMY						350.00	350.00*	350.00	350.00	350.00
057 CHOLECYSTECTOMY						580.00	463.50*	475.00	499.10*	570.40*
058 PERINEAL PLASTY						360.00	285.20*	300.00	263.80*	320.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY	45.00	45.00	45.00	45.00	45.00	35.70*	60.00	50.00*	35.70*	71.30*
060 DILATION OF URETHRA						14.30*	14.30*	17.10*	21.40*	21.40*
061 PROSTATECTOMY						634.50*	684.50*	684.50*	570.40*	684.50*
062 ELECTROSECTION-PROSTATE (TUR)	499.10*	499.10*	499.10*	499.10*	613.00*	570.40*	570.40*	570.40*	570.40*	713.00*
063 HYSTERECTOMY						641.70*	641.70*	641.70*	641.70*	641.70*
064 INITIAL COMPLETE EYE EXAM						20.00	22.80*	20.00	20.00	25.00
065 COMPREHENSIVE EYE EXAM						20.00	22.80*	20.00	20.00	25.00
066 EYE EXAM WITH TONOMETRY						12.00	14.30*	8.60*	10.00	14.30*
067 EXTRACTION OF LENS	499.10*	570.40*	499.10*	570.40*	641.70*	570.40*	570.40*	499.10*	570.40*	641.70*
068 CHEST X-RAY, SINGLE VIEW	15.00	17.10*	17.10*	15.00*	17.10*	10.70*	10.70*	8.60*	15.00*	12.00*
069 CHEST X-RAY, TWO VIEWS	15.00	21.40*	21.40*	25.00	21.40*	25.70	17.80*	25.70*	21.40*	21.40*
070 X-RAY SPINE						40.00	40.00	40.00	40.00	40.00
071 X-RAY HIP						25.70*	25.70*	25.70*	25.70*	24.20*
072 X-RAY UPPER GI TRACT	25.70*	35.70*	35.70*	35.70*	35.70*	49.90*	49.90*	49.90*	42.80*	35.00*
073 X-RAY COLON						42.80*	35.70*	42.80*	42.80*	38.00*
074 RADIATION THERAPY-LOW VOLT	17.80*	17.80*	17.80*	17.80*	14.30*	17.80*	17.80*	17.80*	17.80*	15.00*
075 RADIATION THERAPY-SUPER VOLT	25.70*	25.70*	25.70*	21.40*	25.70*	25.70*	25.70*	25.70*	21.40*	25.70*
076 RADIATION THERAPY-MEGAVOLT						30.00	30.00	30.00	30.00	40.00*
077 CAT SCAN - HEAD	150.00*	150.00*	150.00*	150.00*	150.00*	150.00*	150.00*	150.00*	150.00*	150.00*
078 CAT SCAN-HEAD, INTERPRET ONLY										
079 THREE CHEMISTRY TESTS	80	1.70	1.50			80	1.70	1.50	2.60	1.40
080 TWELVE CHEMISTRY TESTS	8.50	14.00	7.50			8.50	14.00	7.50	12.00	8.50
081 CULTURE-OTHER THAN BLOOD	3.00	2.50	3.00			3.00	2.50	3.00	3.00	3.00
082 REAGGLOBIN										
083 ALBUMIN TO BLOOD COUNT										
084 WHITE CELL COUNT	4.00	4.00	3.50			4.00	4.00	3.50	3.00	3.00
085 COMPLETE BLOOD COUNT (CBC)	8.00	10.00	8.00			8.00	10.00	8.00	12.00	8.00
086 CHOLESTEROL TEST	5.00	6.00	8.00			5.00	6.00	8.00	7.00	5.00
087 FLOCCULATION TEST	5.00	2.00	5.00			5.00	2.00	5.00	5.00	3.00
088 HEMATOCRIT	4.00	3.00	3.00			4.00	3.00	3.00	4.00	3.00
089 PLATELET COUNT (REES-ECKER)	5.00	5.00	5.75			5.00	5.00	5.75	5.00	3.00
090 POTASSIUM TEST	7.00	6.00	6.00			7.00	6.00	6.00	7.00	5.00
091 PROTHROMBIN	6.00	5.00	5.00			6.00	5.00	5.00	5.00	4.50
092 SEDIMENTATION RATE	4.00	3.50	5.00			4.00	3.50	5.00	5.00	5.00
093 BLOOD SUGAR	5.00	5.00	5.00			5.00	5.00	5.00	6.00	4.00
094 BUN-UREA,NITROGEN	6.00	5.25	5.00			6.00	5.25	5.00	10.00	5.00
095 URIC ACID	6.00	6.00	7.00			6.00	6.00	7.00	8.00	5.00
096 FECES-OCULT BLOOD	3.30	3.00	3.00			3.30	3.00	3.00	3.00	2.00
097 PAP TEST	6.00	10.00	10.00			6.00	10.00	10.00	7.00	8.00
098 ROUTINE URINALYSIS	4.00	3.00	5.00			4.00	3.00	5.00	4.00	4.00
099 CHEMICAL URINALYSIS	3.75	3.00	3.75			3.75	3.00	3.75	3.75	3.00
100 PATHOLOGY-THREE SPECIMENS	17.00	15.00	18.00			17.00	15.00	18.00	18.00	20.00

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	11	12	13	14	15	11	12	13	14	15
001 INITIAL BRIEF OFFICE VISIT	15.00	15.00*	15.00	15.00	14.30*	11.40*	10.00*	12.00	14.30*	10.00*
002 INITIAL LIMITED OFFICE VISIT						21.40*	15.00*	21.40*	21.40*	13.00
003 INIT INTERMED OFFICE VISIT	40.00	30.00	35.00	35.70*	35.00	40.00	35.00	40.00	50.00	35.70*
004 INIT COMP OFFICE VISIT	14.00	11.40*	11.40*	11.40*	11.40*	14.30*	9.00	10.00*	12.60*	12.00*
005 MINIMAL F/U OFFICE VISIT	11.40*	8.60*	8.60*	8.60*	8.60*	11.40*	10.00*	12.00	14.30*	10.00*
006 BRIEF F/U OFFICE VISIT	15.00	15.00*	15.00	15.00	14.30*	21.40*	15.00*	21.40*	21.40*	13.00
007 LIMITED F/U OFFICE VISIT	15.00	15.00*	15.00	15.00	14.30*	21.40*	15.00*	21.40*	21.40*	13.00
008 INTERMED F/U OFFICE VISIT	40.00	30.00	35.00	35.70*	35.00	40.00	35.00	40.00	50.00	35.70*
009 EXTENDED F/U OFFICE VISIT	40.00	30.00	35.00	35.70*	35.00	40.00	35.00	40.00	50.00	35.70*
010 COMPLETE F/U OFFICE VISIT	17.10*	12.00	14.30*	14.30*	14.30*	17.10*	17.10*	15.00	14.30*	10.50*
011 BRIEF F/U HOME VISIT						17.10*	17.10*	15.00	14.30*	10.50*
012 LIMITED F/U HOME VISIT	17.10*	12.00	14.30*	14.30*	14.30*	17.10*	17.10*	15.00	14.30*	10.50*
013 INTERMED F/U HOME VISIT						8.00	12.00	12.00	14.30*	12.00
014 EXTENDED CARE FACILITY VISIT	11.40*	8.60*	8.60*	8.60*	8.60*	11.40*	10.00*	12.00	12.00	10.00
015 BRIEF F/U NURSING HOME VISIT	21.40*	28.00	21.40*	21.40*	21.40*	28.50*	28.50*	35.00	35.00	35.70*
016 INITIAL BRIEF HOSPITAL VISIT						35.70*	35.70*	63.00	35.70*	42.80*
017 INIT INTERMED HOSPITAL VISIT						50.00	49.90*	63.00	57.00*	42.80*
018 INITIAL COMP HOSPITAL VISIT	50.00	40.00	35.70*	40.00	35.00	50.00	49.90*	63.00	57.00*	42.80*
019 BRIEF F/U HOSPITAL VISIT	11.40*	10.00*	8.60*	8.60*	10.00*	11.40*	12.80*	14.00	14.30*	11.40*
020 LIMITED F/U HOSPITAL VISIT	21.40*	28.00	21.40*	21.40*	21.40*	28.50*	28.50*	35.00	35.00	35.70*
021 INTERMED F/U HOSPITAL VISIT	21.40*	28.00	21.40*	21.40*	21.40*	28.50*	28.50*	35.00	35.00	35.70*
022 EXTENDED F/U HOSPITAL VISIT						21.40*	18.00	21.40*	17.00	14.30*
023 BRIEF EMERGENCY ROOM VISIT						21.40*	18.00	21.40*	17.00	14.30*
024 LIMITED EMERGENCY ROOM VISIT	45.00	25.00	63.00	49.90*	28.50*	21.40*	18.00	21.40*	17.00	14.30*
025 INTERMED EMERGENCY ROOM VISIT						49.90*	42.80*	42.00	42.80*	35.70*
026 LIMITED CONSULTATION						49.90*	42.80*	42.00	42.80*	35.70*
027 EXTENSIVE CONSULTATION						49.90*	42.80*	42.00	42.80*	35.70*
028 COMPREHENSIVE CONSULTATION						54.20*	45.60*	54.20*	45.60*	38.50*
029 PSYCHOTHERAPY-ONE HOUR						26.50*	35.00*	42.80*	28.50*	25.00
030 PSYCHOTHERAPY-HALF HOUR						30.00	28.50*	29.00	29.00	35.00
031 CHIROPRACTIC OFFICE VISIT	11.40*	10.00	9.00	9.00	10.00	10.00*	10.00	9.00	9.00	10.00
032 INITIAL PHYSIOTHERAPY										
033 F/U PODIATRIC OFFICE VISIT	28.50*	21.40*	21.40*	20.00	20.00	11.40*	10.00*	10.00	10.00	10.00
034 ELECTROCARDIOGRAM (EKG)	10.70*	11.40*	11.40*	15.00	14.30*	28.50	22.00	21.40*	20.00	18.50*
035 EKG-INTERPRET. REPORT ONLY						7.50	7.10*	10.00	10.00	10.00
036 ARTERIAL BLOOD GAS STUDY						21.40*	21.40*	21.40*	21.40*	21.40*
037 ELECTROENCEPHALOGRAPH (EEG)						57.00*	57.00*	57.00*	57.00*	57.00*
038 CHEMOTHERAPY										
039 COLLECTION OF SPECIMENS						5.00	6.00	3.00	5.00	6.00
040 DEBRIDEMENT OF NAILS						14.30*	14.30	10.00	12.00	14.30*
041 SKIN BIOPSY						35.00	35.00	35.00	35.00	20.00
042 CHEMOCAUTERY						22.50	22.50	22.50	22.50	20.00
043 RADICAL MASTECTOMY						570.40*	713.00*	713.00*	713.00*	713.00*
044 OPEN REDUCTION OF FRACTURE						641.70*	713.00*	713.00*	713.00*	900.00
045 ARTHROCENTESIS-MAJOR JOINT						21.40*	21.40*	21.40*	21.40*	21.40*
046 ARTHROTOMY						21.40*	21.40*	21.40*	21.40*	21.40*
047 ARTHROPLASTY-REPAIR OF HIP	21.40*	18.50*	14.30*	17.00	15.00	1162.20	1162.20	1162.20	1162.20	1162.20
048 NEEDLE PUNCTURE OF BURSA						14.30*	14.30*	14.30*	14.30*	14.30*
049 BRONCHOSCOPY						142.60*	142.60*	142.60*	142.60*	142.60*
050 THORACENTESIS						49.90*	49.90*	49.90*	49.90*	49.90*

1979 PREVAILING CHARGE SUMMARY DATA

OHIO

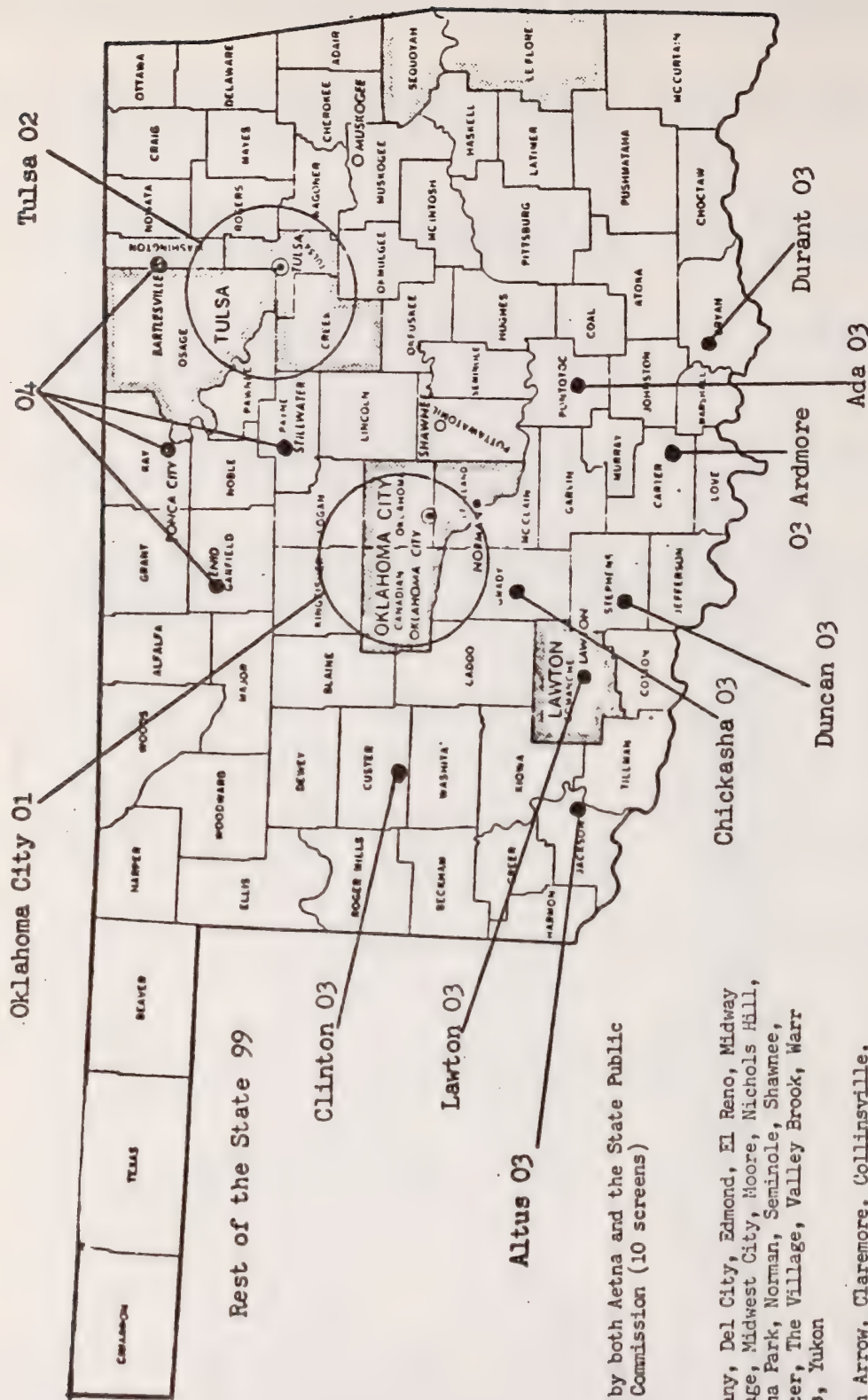
NATIONWIDE MUTUAL INSURANCE CO.

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	11	12	13	14	15	11	12	13	14	15
051 CATHETERIZATION OF HEART						427.80*	427.80*	427.80*	427.80*	427.80*
052 INSERTION OF PACEMAKER						845.00	845.00	845.00	845.00	845.00
053 PARTIAL COLECTOMY						713.00*	600.00	713.00*	685.00	635.00
054 APENDECTOMY						356.50*	356.50*	356.50*	356.50*	356.50*
055 SIGMOIDOSCOPY						42.80*	28.50*	21.40*	25.00	21.40*
056 HEMORRHOIDECTOMY						350.00	350.00	350.00	213.90*	350.00
057 CHOLECYSTECTOMY						641.70*	499.10*	570.40*	499.10*	515.00
058 REPAIR HERNIA						356.50*	299.00	285.20*	325.00	320.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY						60.00	35.70*	60.00	71.30*	60.00
060 DILATION OF URETHRA						15.00	17.10*	17.10*	20.00	14.30*
061 PROSTATECTOMY						713.00*	684.50*	684.50*	684.50*	684.50*
062 ELECTROSECTION-PROSTATE (TUR)						684.50*	570.40*	684.50*	570.40*	700.00
063 HYSTERECTOMY						664.10*	641.70*	641.70*	641.70*	641.70*
064 INITIAL COMPLETE EYE EXAM						25.00	22.80*	21.40*	21.40*	22.80*
065 COMPREHENSIVE EYE EXAM						25.00	22.80*	21.40*	21.40*	22.80*
066 EYE EXAM WITH TONOMETRY						12.00	10.00	18.00	13.00	12.00
067 EXTRACTION OF LENS						641.70*	499.10*	684.50*	570.40*	534.75*
068 CHEST X-RAY, SINGLE VIEW						24.20*	10.70*	15.70*	10.00*	10.00
069 CHEST X-RAY, TWO VIEWS						25.50	25.00	22.80*	25.70*	10.00
070 X-RAY SPINE						39.50	40.00	40.00	40.00	40.00
071 X-RAY HIP						25.00	25.70*	25.70*	25.70*	25.70*
072 X-RAY UPPER GI TRACT						57.00	49.90*	38.00*	49.90*	35.00
073 X-RAY COLON						49.90*	42.80*	32.00*	42.80*	35.00
074 RADIATION THERAPY-LOW VOLT						14.30*	16.25*	14.30*	17.80*	10.00
075 RADIATION THERAPY-SUPER VOLT						21.40*	19.00*	25.70*	25.70*	25.70*
076 RADIATION THERAPY-MEGAVOLT						30.00*	30.00	30.00	30.00	15.00
077 CAT SCAN - HEAD						150.00*	150.00*	150.00*	150.00*	150.00*
078 CAT SCAN-HEAD, INTERPRET ONLY										
079 THREE CHEMISTRY TESTS						1.70	1.50	1.25	1.20	1.00
080 TWELVE CHEMISTRY TESTS						15.00	7.00	12.00	10.00	8.00
081 CULTURE-OTHER THAN BLOOD						4.00	3.00	3.00	4.00	3.00
082 HEMOGLOBIN										
083 AUTOMATED BLOOD COUNT						5.00	3.00	2.50	4.00	2.00
084 WHITE CELL COUNT						10.00	7.00	7.50	6.00	8.00
085 COMPLETE BLOOD COUNT (CBC)						7.00	6.00	5.50	7.00	5.00
086 CHOLESTEROL TEST						8.00	5.00	5.00	5.00	6.00
087 FLOCCULATION TEST						5.00	3.00	2.00	4.00	4.00
088 HEMATOCRIT						6.00	4.00	3.00	4.00	6.00
089 PLATELET COUNT (REES-ECKER)						8.00	5.00	6.00	6.00	5.00
090 POTASSIUM TEST						6.00	6.00	5.00	6.00	6.00
091 PROTHROMBIN						5.00	4.00	3.00	4.00	5.00
092 SEDIMENTATION RATE						6.00	5.00	5.00	6.00	5.00
093 BLOOD SUGAR						6.00	5.00	5.00	6.00	5.00
094 BUN-UREA, NITROGEN						7.00	6.00	5.00	5.00	5.50
095 URIC ACID						7.00	5.00	6.00	5.00	7.00
096 FECES-OCULT BLOOD						3.00	3.00	2.00	2.50	2.00
097 PAP TEST						8.00	10.00	8.00	7.00	8.00
098 ROUTINE URINALYSIS						5.00	3.00	3.00	4.00	4.00
099 CHEMICAL URINALYSIS						3.75	3.75	3.75	3.00	1-25
100 PATHOLOGY-THREE SPECIMENS						18.00	18.00	15.00	12.00	17.00

OKLAHOMA

OKLAHOMA



Five Localities: handled by both Aetna and the State Public Welfare Commission (10 screens)

01 - Oklahoma City: Bethany, Del City, Edmond, El Reno, Midway Village, Midwest City, Moore, Nichols Hill, Nicoma Park, Norman, Seminole, Shawnee, Spencer, The Village, Valley Brook, Warr Acres, Yukon

02 - Tulsa: Bixby, Broken Arrow, Claremore, Collinsville, Coweta, Jenks, Oakhurst, Owasso, Prattville, Sand Springs, Sapulpa, Skiatook, Turley, McAlester, Muskogee, Okmulgee, Catoosa

03 - Ada, Ardmore, Durant, Chickasha, Lawton, Altus, Clinton, Duncan

04 - Enid, Ponca City, Bartlesville, Stillwater

99 - All other

(Locality is determined by the city cited in the return address.)

1979 PREVAILING CHARGE SUMMARY DATA AETNA LIFE AND CASUALTY

OKLAHOMA

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

01

02

03

04

99

01

02

03

04

99

001 INITIAL BRIEF OFFICE VISIT

21.30*

20.00

15.00*

16.00

001

002 INITIAL LIMITED OFFICE VISIT

35.60*

42.80*

33.00

40.00*

002

003 INIT INTERMED OFFICE VISIT

21.30*

13.60*

13.60*

42.00*

003

004 INIT COMP OFFICE VISIT

49.40*

64.10*

45.00

55.00

004

005 MINIMAL F/U OFFICE VISIT

5.92*

4.20*

2.50

7.20*

005

006 BRIEF F/U OFFICE VISIT

11.40*

14.30*

8.60*

8.60*

006

007 LIMITED F/U OFFICE VISIT

14.30*

14.30*

14.30*

15.00

007

008 EXTENDED F/U OFFICE VISIT

20.50

19.00

15.00*

15.00

008

009 INTERMED F/U OFFICE VISIT

30.00

30.00

20.00

29.60*

009

010 COMPLETE F/U OFFICE VISIT

42.80*

49.90*

35.60*

55.00

010

011 BRIEF F/U HOME VISIT

15.00

12.50*

12.50*

10.30*

011

012 LIMITED F/U HOME VISIT

20.00*

32.40

20.00

24.60

012

013 INTERMEDIATE F/U HOME VISIT

20.00*

32.40

20.00

24.60

013

014 EXTENDED CARE FACILITY VISIT

15.00

10.00*

10.30

10.50

014

015 BRIEF F/U NURSING HOME VISIT

11.40*

14.30*

8.60

8.60*

015

016 INITIAL BRIEF HOSPITAL VISIT

35.00*

35.60*

25.00*

28.50*

016

017 INIT INTERMED HOSPITAL VISIT

42.80*

42.80*

35.60*

36.75*

017

018 INITIAL COMP HOSPITAL VISIT

57.00*

64.10*

49.90*

40.00

018

019 BRIEF F/U HOSPITAL VISIT

14.30

14.30*

14.30*

14.30*

019

020 LIMITED F/U HOSPITAL VISIT

20.50

20.00

21.30*

20.00

020

021 INTERMED F/U HOSPITAL VISIT

21.30*

14.30*

18.70*

14.30*

021

022 EXTENDED F/U HOSPITAL VISIT

16.00

16.00

15.70*

25.25*

022

023 BRIEF EMERGENCY ROOM VISIT

35.70*

36.00*

30.60*

35.40*

023

024 LIMITED EMERGENCY ROOM VISIT

23.00*

21.80*

21.20*

52.50

024

025 INTERMED EMERGENCY ROOM VISIT

31.60*

35.00*

35.00*

35.00*

025

026 LIMITED CONSULTATION

42.80*

50.00*

35.60*

42.00*

026

027 EXTENSIVE CONSULTATION

50.00*

70.00

49.90*

57.00*

027

028 COMPREHENSIVE CONSULTATION

50.00

41.80*

38.00*

35.00

028

029 PSYCHOTHERAPY-ONE HOUR

30.00

20.90*

19.00*

28.40*

029

030 PSYCHOTHERAPY-HALF HOUR

10.00*

10.00*

10.00

10.00

030

031 CHIROPRACTIC OFFICE VISIT

11.16

10.63

11.16

17.16

031

032 INITIAL PHYSIOTHERAPY

12.00

14.30*

10.00*

12.00

032

033 F/U PODIATRIC OFFICE VISIT

20.00

20.00

20.00

21.30*

033

034 ELECTROCARDIOGRAM (EKG)

10.00*

8.50*

8.50

8.50*

034

035 EKG-INTERPRET-REPORT ONLY

79.80

157.30*

72.10

73.50

035

036 ARTERIAL BLOOD GAS STUDY

55.00

57.00

82.60

82.60

036

037 ELECTROENCEPHALOGRAPH (EEG)

16.00*

10.00

10.00

19.90*

037

038 CHEMOTHERAPY

5.00

7.10

3.00

5.00

038

039 COLLECTION OF SPECIMENS

14.30*

14.30*

14.30

13.50

039

040 DEBRIDEMENT OF NAILS

21.30*

40.00

23.60*

35.00

040

041 SKIN BIOPSY

14.30*

15.10*

14.30*

32.10*

041

042 CHEMOCAUTERY

713.00*

713.00*

713.00*

589.50*

042

043 RADICAL MASTECTOMY

641.70

798.60

570.40*

677.40*

043

044 OPEN REDUCTION OF FRACTURE

21.30

21.50

21.30*

27.90

044

045 ARTHROCENTESIS-MAJOR JOINT

15.00

21.20

17.10*

15.00*

045

046 ARTHROTOMY

1137.50

1337.50

1087.50

1075.00

046

047 ARTHROPLASTY-REPAIR OF HIP

20.00

20.00

18.40*

1979 PREVAILING CHARGE SUMMARY DATA

OKLAHOMA

AETNA LIFE AND CASUALTY

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

01 02 03 04 99

01 02 03 04 99

051	CATHERIZATION OF HEART	285.20*	350.00*	450.00	364.50	427.50	051
052	INSERTION OF PACEMAKER	1330.00	822.70	1000.00	610.00	950.00	052
053	PARTIAL COLECTOMY	713.00*	798.60*	680.00	700.00	824.50*	053
054	APENDICECTOMY	392.20*	420.00	342.00	356.50*	356.50*	054
055	SIGMOIDOSCOPY	28.50*	27.50	28.00	35.00	21.30*	055
056	HEPATOMY	350.00	320.80*	231.00	256.70*	256.70*	056
057	CHOLECYSTECTOMY	534.75*	570.40*	513.40*	499.10*	499.10*	057
058	REPAIR HERNIA	350.50*	370.80*	320.80*	350.00	320.80*	058
059	DIAGNOSTIC CYSTOURETHROSCOPY	35.00*	42.80*	35.60	40.00	38.60*	059
060	DILATION OF URETHRA	15.00*	14.30*	13.20	14.30*	14.30*	060
061	PROSTATECTOMY	641.70*	750.00	713.00*	615.00*	744.00	061
062	ELECTROSECTION-PROSTATE (TUR)	641.70*	700.00	570.40*	627.30*	616.00	062
063	HYSTARECTOMY	641.70*	713.00*	641.70*	600.00	539.00*	063
064	INITIAL COMPLETE EYE EXAM	20.50*	25.00	21.30*	22.30*	15.00	064
065	COMPREHENSIVE EYE EXAM	30.00	22.80*	30.00	30.00	30.00	065
066	EYE EXAM WITH TORICITY	10.00*	12.00	15.00	12.00	15.00	066
067	EXTRACTION OF LENS	570.40*	570.40*	570.40*	570.40*	499.10*	067
068	CHEST X-RAY, SINGLE VIEW	17.10*	17.10*	15.00*	17.10*	15.00*	068
069	CHEST X-RAY, TWO VIEWS	24.00*	27.50	20.00	20.00	19.29*	069
070	X-RAY SPINE	25.36*	28.50*	25.00*	25.00*	25.00*	070
071	X-RAY HIP	21.25*	25.70*	21.30*	21.30*	28.00	071
072	X-RAY UPPER GI TRACT	42.80*	45.00	40.00*	45.00*	40.00*	072
073	X-RAY COLON	31.80*	42.80*	38.03*	30.00	38.03*	073
074	RADIATION THERAPY-LOW VOLT	20.10	15.00	15.00	15.00	21.00	074
075	RADIATION THERAPY-MEDIUM VOLT	25.00	22.50	19.20	25.00	21.00	075
076	RADIATION THERAPY-NEGAVOLT	15.00	15.00	15.00	15.00	15.00	076
077	CAT SCAN - HEAD	150.00	150.00	150.00	150.00	150.00	077
078	CAT SCAN-HEAD, INTERPRET ONLY	51.80*	51.80*	51.80*	51.80*	51.80*	078
079	THREE CHEMISTRY TESTS	20.00	22.00	15.00	15.00	15.00	079
080	TWELVE CHEMISTRY TESTS	20.00	22.00	25.50	15.00	32.64	080
081	CULTURE-OTHER THAN BLOOD	13.00*	10.00	7.50	15.00	15.00	081
082	HEMATOCRIT	5.00	3.00	4.00	4.00	4.00	082
083	HAEMOGLOBIN	11.00	10.00	11.00	11.00	11.00	083
084	WHITE CELL COUNT	5.00*	4.50	3.00	4.00	5.00	084
085	DIFFERENTIAL BLOOD COUNT (CBC)	10.00	10.00	9.50	9.50	8.64	085
086	CHOLESTEROL TEST	7.50	7.00	8.00	7.25	7.50	086
087	FLOCCULATION TEST	5.50	4.00	5.00	5.00	4.32	087
088	HEMATOCRIT	4.00	4.50	3.50	3.20	4.00	088
089	PLATELET COUNT (REES-ECKER)	6.00	6.00	5.00	5.50	7.00	089
090	POTASSIUM TEST	7.00	8.00	7.50	9.00	9.00	090
091	PROTHROMBIN	5.50	7.05	6.00	6.00	7.00	091
092	SEDIMENTATION RATE	5.50	6.00	6.00	6.00	6.00	092
093	BLOOD SUGAR	7.00	7.00	7.00	7.00	7.00	093
094	BUN-CREANIN	7.00	7.00	8.00	10.00	7.50	094
095	URIC ACID	7.50	8.00	8.00	8.00	7.50	095
096	FECES-OCULT BLOOD	4.50	3.50	3.00	5.00	3.00	096
097	PAP TEST	8.25	9.00	10.00	7.50	12.50	097
098	ROUTINE URINALYSIS	6.00	5.00	5.00	5.00	5.00	098
099	CHEMICAL URINALYSIS	2.60	2.60	2.60	2.60	2.60	099
100	PATHOLOGY-THREE SPECIMENS	18.00	15.00	18.00	14.85	20.00	100

1979 PREVAILING CHARGE SUMMARY DATA

DEPT. OF INST..SOCIAL AND REHAB.

OKLAHOMA

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

01 02 03 04 99

01 02 03 04 99

001 INITIAL BRIEF OFFICE VISIT	28.50*	25.00*	20.00*	28.50*	15.00*	20.00	15.00*	16.00	5.00	001
002 INITIAL LIMITED OFFICE VISIT	37.50	30.00	45.00	35.00*	35.00*	42.80*	33.00	40.00*	25.00	002
003 INIT INTERMED OFFICE VISIT	5.70*	6.00	5.70*	4.20*	5.70*	13.60*	13.60*	13.60*	42.00*	003
004 INIT COMP OFFICE VISIT	5.70*	8.60*	7.20*	4.20*	5.70*	64.10*	45.00	55.00	50.00*	004
005 MINIMAL F/U OFFICE VISIT	14.30*	14.30*	12.00	11.00	11.40*	4.20*	2.50	7.20*	5.00	005
006 BRIEF F/U OFFICE VISIT	14.30*	14.30*	14.30*	20.00	14.30*	14.30*	8.60*	8.60*	7.20*	006
007 LIMITED F/U OFFICE VISIT	15.00	14.30*	14.30*	20.00	14.30*	19.00	15.00*	15.00	14.30*	007
008 INTERMED F/U OFFICE VISIT	26.40*	25.25*	25.00	25.00	25.00*	30.00	20.00	50.00	15.40*	008
009 EXTENDED F/U OFFICE VISIT	35.00	25.00	25.00	31.50	31.50	42.80*	35.60*	55.00	29.60*	009
010 COMPLETE F/U OFFICE VISIT	14.30*	14.30*	10.00	14.30*	14.30*	15.00	12.50*	12.50*	35.60*	010
011 BRIEF F/U HOME VISIT	15.00	18.00	21.30*	18.00	21.30*	20.00*	20.00	24.60	10.30*	011
012 LIMITED F/U HOME VISIT	8.60*	8.60*	7.20*	8.60	7.20*	20.00*	20.00	24.60	20.00	012
013 INTERMEDIATE F/U HOME VISIT	28.50*	25.00*	21.30*	21.30*	21.30*	15.00	10.30	10.50	20.00	013
014 EXTENDED CARE FACILITY VISIT	45.00	44.00	42.80*	49.90*	35.60*	11.40*	8.60	8.60*	13.30*	014
015 BRIEF F/U NURSING HOME VISIT	14.30*	14.30*	10.00*	10.00*	11.40*	35.00*	25.00*	28.50*	7.20	015
016 INITIAL BRIEF HOSPITAL VISIT	10.00	20.00*	15.00*	18.00*	20.00*	42.80*	35.60*	35.60*	30.00*	016
017 INIT INTERMED HOSPITAL VISIT	14.30*	14.30*	10.00*	10.00*	11.40*	57.00*	49.90*	50.00*	36.75*	017
018 INITIAL COMP HOSPITAL VISIT	10.00	20.00*	15.00*	18.00*	20.00*	14.30	14.30*	14.30*	40.00	018
019 BRIEF F/U HOSPITAL VISIT	14.30*	15.00	12.20*	10.70*	10.00*	20.50	21.30*	20.00	11.40*	019
020 LIMITED F/U HOSPITAL VISIT	21.30*	21.30*	21.30*	21.30*	21.30*	21.30*	18.70*	10.00*	21.30*	020
021 INTERMED F/U HOSPITAL VISIT	21.30*	21.30*	21.30*	21.30*	21.30*	21.30*	22.00	25.25*	14.30*	021
022 EXTENDED F/U HOSPITAL VISIT	16.00	16.00	16.00	16.00	16.00	16.00	16.00	15.70*	25.25*	022
023 BRIEF EMERGENCY ROOM VISIT	35.70*	36.00*	30.60*	35.40*	35.40*	35.70*	30.60*	35.40*	32.00*	023
024 LIMITED EMERGENCY ROOM VISIT	23.00*	21.80*	21.20*	21.20*	21.20*	23.00*	21.20*	25.50	22.20*	024
025 INTERMED EMERGENCY ROOM VISIT	35.60*	35.00*	35.00*	35.00*	35.00*	35.60*	35.00*	25.00*	35.00*	025
026 LIMITED CONSULTATION	42.80*	50.00*	35.60*	35.60*	35.60*	42.80*	35.60*	35.60*	35.00*	026
027 EXTENSIVE CONSULTATION	50.00*	70.00	49.90*	57.00*	57.00*	50.00*	49.90*	57.00*	50.00*	027
028 COMPREHENSIVE CONSULTATION	50.00	41.80*	38.00*	35.00	35.00	50.00	38.00*	35.00	47.25*	028
029 PSYCHOTHERAPY-ONE HOUR	30.00	20.90*	19.00*	13.80*	13.80*	30.00	19.00*	13.80*	28.40*	029
030 PSYCHOTHERAPY-HALF HOUR	10.00*	10.00*	10.00*	10.00*	10.00*	10.00	9.00	10.00	10.00	030
031 CHIROPRACTIC OFFICE VISIT	11.16	10.68	11.16	11.16	11.16	11.16	11.16	11.16	11.16	031
032 INITIAL PHYSIOTHERAPY	12.00	14.30*	10.00*	12.00	10.00*	12.00	10.00*	12.00	10.00*	032
033 F/U PODIATRIC OFFICE VISIT	20.00	20.00	20.00	21.30*	21.30*	20.00	20.00	21.30*	21.30*	033
034 ELECTROCARDIOGRAM (ECG)	10.00*	8.50*	8.50	10.00	8.50	10.00*	8.50	10.00	8.50*	034
035 EKG-INTERPRET-REPORT ONLY	79.80	157.30*	72.10	73.50	73.50	79.80	72.10	73.50	63.00	035
036 ARTERIAL BLOOD GAS STUDY	55.00	57.00	82.60	55.00	82.60	55.00	82.60	55.00	82.60	036
037 ELECTROENCEPHALOGRAPH (EEG)	16.00*	10.00	10.00	10.00	10.00	16.00*	10.00	19.90*	19.90*	037
038 CHEMOTHERAPY	5.00	7.10	3.00	5.00	3.00	5.00	3.00	5.00	5.00	038
039 COLLECTION OF SPECIMENS	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	12.00	13.50	039
040 DEBRIDEMENT OF NAILS	21.30*	40.00	23.60*	35.00	32.10*	21.30*	23.60*	35.00	32.10*	040
041 SKIN BIOPSY	14.30*	14.30*	14.30*	15.10*	14.30*	14.30*	14.30*	14.30*	14.30*	041
042 CHEMOCAUTERY	713.00*	713.00*	713.00*	713.00*	713.00*	713.00*	713.00*	677.40*	589.50*	042
043 RADICAL MASTECTOMY	641.70	798.60	570.40*	641.70*	570.40*	641.70	570.40*	641.70*	713.00*	043
044 OPEN REDUCTION OF FRACTURE	21.30	21.50	21.30*	21.50	21.30*	21.30	21.30*	21.50	27.90	044
045 ARTHROCENTESIS-MAJOR JOINT	15.00	21.30	17.10*	20.00*	15.00*	15.00	17.10*	20.00*	15.00*	045
046 ARTHROTOMY	1137.50	1337.50	1087.50	1075.00	1162.50	1137.50	1087.50	1075.00	1162.50	046
047 ARTHROPLASTY-REPAIR OF HIP	20.00	20.00	18.40*	20.00	20.00	20.00	20.00	18.40*	20.00	047
048 NEEDLE PUNCTURE OF BURSA	114.10*	115.60*	115.60*	115.60*	115.60*	114.10*	115.60*	115.60*	115.60*	048
049 BRONCHOSCOPY	35.00	35.00	35.00	35.00	35.00	35.00	35.00	35.00	35.00	049
050 THORACENTESIS										050

1979 PREVAILING CHARGE SUMMARY DATA DEPT. OF INST..SOCIAL AND REHAB.

OKLAHOMA

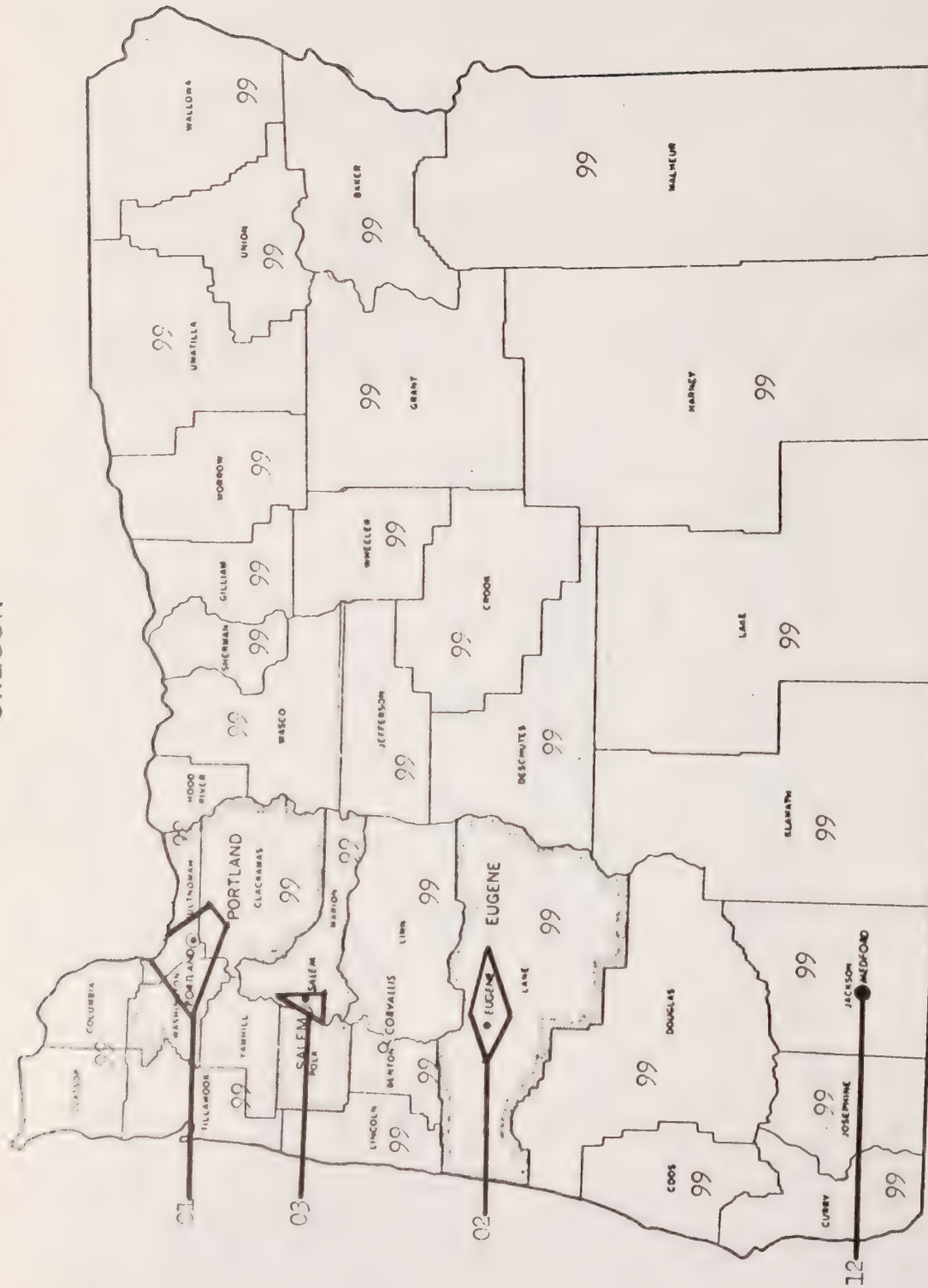
LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	04	99	01	02	03	04	99
051 CATHETERIZATION OF HEART						285.70*	350.00*	450.00	364.50	427.50
052 INSERTION OF PACEMAKER						1330.00	822.70	1000.00	810.00	950.00
053 PARTIAL COLECTOMY						713.00*	798.60*	660.00	700.00	684.50*
054 APPENDECTOMY						392.20*	420.00	342.00	356.50*	356.50*
055 SIGMOIDOSCOPY					28.50*	28.50*	27.50	28.00	35.00	21.30*
056 HEMORRHOIDECTOMY						350.00	320.80*	231.00	265.00*	256.70*
057 CHOLECYSTECTOMY						534.75*	570.40*	513.40*	499.10*	499.10*
058 REPAIR PERNIA						356.50*	370.80*	320.80*	350.00	320.80*
059 DIAGNOSTIC CYSTOURETHROSCOPY						35.60*	42.80*	35.60	40.00	38.60*
060 DILATION OF URETHRA						15.00*	14.30*	13.20	14.30*	14.30*
061 PROSTATECTOMY						641.70*	750.00	713.00*	616.00*	744.00
062 ELECTROSECTION-PROSTATE (TUR)						641.70*	700.00	570.40*	627.30*	616.00
063 HYSTERECTOMY						641.70*	713.00*	641.70*	600.00	539.00*
064 INITIAL COMPLETE EYE EXAM						28.50*	25.00	21.30*	22.80*	15.00
065 COMPREHENSIVE EYE EXAM						30.00	22.80*	30.00	20.00	30.00
066 EYE EXAM WITH TONOMETRY						10.00*	12.00	15.00	12.00	15.00
067 EXTRACTION OF LENS						608.00	640.00	656.00	576.00	600.00
068 CHEST X-RAY, SINGLE VIEW						17.10*	17.10*	16.20	20.00	17.00
069 CHEST X-RAY, TWO VIEWS						24.30*	27.50	20.00	25.70*	21.30*
070 X-RAY SPINE										
071 X-RAY HIP										
072 X-RAY UPPER GI TRACT						49.90*	49.90*	40.00*	42.80*	49.90*
073 X-RAY COLON										
074 RADIATION THERAPY-LOW VOLT						25.20	21.30*	21.60	26.10	23.70
075 RADIATION THERAPY-SUPER VOLT						33.60	34.00	21.60	26.10	23.70
076 RADIATION THERAPY-MEGAVOLT										
077 CAT SCAN - HEAD						150.00	150.00	150.00	150.00	150.00
078 CAT SCAN-HEAD, INTERPRET ONLY						150.00	150.00	150.00	150.00	150.00
079 THREE CHEMISTRY TESTS						51.80*	51.80*	51.80*	51.80*	51.80*
080 TWELVE CHEMISTRY TESTS						20.00	22.00	25.50	15.00	15.00
081 CULTURE-OTHER THAN BLOOD						20.00	22.00	25.50	15.00	15.00
082 HEMOGLOBIN						13.00	10.00	7.50	15.00	15.00
083 AUTOMATED BLOOD COUNT						5.00	3.00	4.00	4.00	4.00
084 WHITE CELL COUNT						11.00	10.00	11.00	11.00	11.00
085 COMPLETE BLOOD COUNT (CBC)						5.00	4.50	3.00	4.00	5.00
086 CHOLESTEROL TEST						10.00	10.00	9.50	9.60	8.64
087 FLOCCULATION TEST						7.50	7.00	8.00	7.25	7.50
088 HEMATOCRIT						5.50	4.00	5.00	5.00	4.32
089 PLATELET COUNT (REES-ECKER)						4.00	4.50	3.50	3.20	4.00
090 POTASSIUM TEST						6.00	6.00	5.00	5.50	7.00
091 PROTHROMBIN						7.00	8.00	7.50	9.00	9.00
092 SEDIMENTATION RATE						7.00	7.05	6.00	6.00	7.00
093 BLOOD SUGAR						5.50	6.00	6.00	6.00	6.00
094 SUN-UREA, NITROGEN						7.00	7.00	7.00	6.00	7.00
095 URIC ACID						7.50	8.00	8.00	10.00	7.50
096 FECES-OCCULT BLOOD						7.50	8.00	8.00	8.00	7.50
097 PAP TEST						4.50	3.50	5.00	5.00	3.00
098 ROUTINE URINALYSIS						8.25	9.00	10.00	7.50	12.50
099 CHEMICAL URINALYSIS						6.00	5.00	5.00	5.00	5.00
100 PATHOLOGY-THREE SPECIMENS						2.60	2.60	2.60	2.60	2.60
						18.00	15.00	18.00	14.85	20.00

OREGON

OREGON



Five Localities:

- 01 - Portland - Aloha, Battin, Beaverton, Cedar Hills, Collins View, Powellhurst, Raleigh Hills, Riverdale, Robin Hood, Sandy Sylvan, Errol Heights, Garden Home, Gilbert, Gladstone, Glendoveer, Gresham, Hazelwood, Hillsboro, Jennings Lodge, Kelly Butte, Lake Oswego, Marlene Village, Metzger, Milwaukee, Oakgrove, Oregon City, Parkrose, Tigard, West Linn, West Portland, West Portland Park, West Powellhurst, West Slope

- 02 - Eugene - Glenwood, River Road, Santa Clara, Springfield, Veneta. Coos Bay and Roseburg

- 03 - Salem - Four Corners, Hayesville, Keizer, Corvallis, Albany, Lebanon
 12 - Medford, Klamath Falls, Grant's Pass
 99 - Rest of State
 (Locality determined by city cited in return address.)

1979 PREVAILING CHARGE SUMMARY DATA

AETNA LIFE AND CASUALTY

OREGON

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

01

02

03

12

99

01

02

03

12

99

001	INITIAL BRIEF OFFICE VISIT	30.00	15.00	20.00	24.00	18.00	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	001
002	INITIAL LIMITED OFFICE VISIT						30.00	23.60	25.00	26.00	26.00	26.00	26.00	26.00	26.00	002
003	INIT INTERMED OFFICE VISIT						51.90*	47.00	49.00	49.00	49.00	49.00	49.00	49.00	49.00	003
004	INIT COMP OFFICE VISIT	49.90*	49.90*	45.00	51.30*	56.00	57.00*	57.00*	43.90*	43.90*	43.90*	43.90*	43.90*	43.90*	43.90*	004
005	MINIMAL F/U OFFICE VISIT	7.20*	5.70*	7.20*	7.20*	5.70*	8.50	5.70*	5.70*	5.70*	5.70*	5.70*	5.70*	5.70*	5.70*	005
006	BRIEF F/U OFFICE VISIT	10.70*	11.40*	10.00	10.00*	8.90*	12.80	11.40*	11.40*	11.40*	11.40*	11.40*	11.40*	11.40*	11.40*	006
007	LIMITED F/U OFFICE VISIT	12.75*	14.30*	14.00	14.00	12.80	14.30*	15.00	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	007
008	INTERMED F/U OFFICE VISIT	14.50	21.30*	16.00	17.00	14.50	19.00	17.00	13.00	14.30*	14.30*	14.30*	14.30*	14.30*	14.30*	008
009	EXTENDED F/U OFFICE VISIT	26.50*	26.95	25.00	21.00	25.00	28.50*	28.00	28.50	28.00	24.00	24.00	24.00	24.00	24.00	009
010	COMPLETE F/U OFFICE VISIT	42.80*	35.60*	40.00	35.60*	35.60*	49.90*	42.80*	45.00	45.00	40.00	40.00	40.00	35.60*	35.60*	010
011	BRIEF F/U HOME VISIT	21.30*	20.00	16.25	15.00	14.30*	21.30*	17.40	17.40	17.40	17.40	17.40	17.40	17.40	17.40	011
012	LIMITED F/U HOME VISIT						28.50*	28.50*	21.50	21.50	27.30	27.30	27.30	27.30	27.30	012
013	INTERMEDIATE F/U HOME VISIT	24.00	21.30	18.00	25.70*	20.00	28.50*	28.50*	21.50	21.50	27.30	27.30	27.30	27.30	27.30	013
014	EXTENDED CARE FACILITY VISIT						15.00	10.90	17.50	17.50	10.00	10.00	10.00	10.00	10.00	014
015	BRIEF F/U NURSING HOME VISIT	14.30*	14.30*	12.75	14.30*	10.00*	14.30*	21.30*	14.30	14.30	14.30*	14.30*	14.30*	14.30*	14.30*	015
016	INITIAL BRIEF HOSPITAL VISIT	21.30*	21.30*	21.30*	21.30*	21.30*	35.60*	35.60*	21.30*	21.30*	21.30*	21.30*	21.30*	21.30*	21.30*	016
017	INIT INTERMED HOSPITAL VISIT						57.00*	57.00*	57.00*	57.00*	57.00*	57.00*	57.00*	57.00*	57.00*	017
018	INITIAL COMP HOSPITAL VISIT	49.90*	49.90*	49.90*	55.70*	49.90*	57.00*	57.00*	57.00*	57.00*	47.20*	47.20*	47.20*	47.20*	47.20*	018
019	BRIEF F/U HOSPITAL VISIT	10.70*	10.70*	10.00*	10.00*	10.00*	14.30*	14.30*	14.30	14.30	12.00	12.00	12.00	12.00	12.00	019
020	LIMITED F/U HOSPITAL VISIT	15.00	15.00	15.00	16.00	15.00	16.50	17.00	16.50	16.50	14.30*	14.30*	14.30*	14.30*	14.30*	020
021	INTERMED F/U HOSPITAL VISIT	15.00*	13.00*	13.00*	13.00*	12.00	13.00*	18.20*	13.00	13.00	13.00	13.00	13.00	13.00	13.00	021
022	EXTENDED F/U HOSPITAL VISIT						27.40*	27.40*	25.00*	25.00*	22.00	22.00	22.00	22.00	22.00	022
023	BRIEF EMERGENCY ROOM VISIT						17.00	20.50*	18.90	19.30*	19.30*	20.00	20.00	20.00	20.00	023
024	LIMITED EMERGENCY ROOM VISIT						17.00	27.30*	25.20	25.20	24.80*	24.80*	24.80*	24.80*	24.80*	024
025	INTERMED EMERGENCY ROOM VISIT						20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	025
026	LIMITED CONSULTATION	16.80*	27.10*	25.00	25.00	25.00	38.00*	36.50	35.00	35.00	33.00	33.00	33.00	33.00	33.00	026
027	EXTENSIVE CONSULTATION						49.00*	45.00*	46.00*	46.00*	55.00	55.00	55.00	55.00	55.00	027
028	COMPREHENSIVE CONSULTATION						68.50*	57.00*	49.90*	49.90*	50.00*	50.00*	50.00*	50.00*	50.00*	028
029	PSYCHOTHERAPY-ONE HOUR						44.30*	30.40*	34.10*	34.10*	50.00	50.00	50.00	50.00	50.00	029
030	PSYCHOTHERAPY-HALF HOUR						30.00	16.80*	17.00*	17.00*	11.40*	11.40*	11.40*	11.40*	11.40*	030
031	CHIROPRACTIC OFFICE VISIT	10.00*	10.00*	10.00*	10.90*	8.60*	10.20*	10.20*	10.20*	10.20*	11.10*	11.10*	11.10*	11.10*	11.10*	031
032	INITIAL PHYSIOTHERAPY						9.72	9.72	10.00*	10.00*	10.00*	10.00*	10.00*	10.00*	10.00*	032
033	F/U PODIATRIC OFFICE VISIT	22.50	21.30*	24.00	25.00	22.80*	21.30*	25.20	21.30*	21.30*	24.00	24.00	24.00	24.00	24.00	033
034	ELECTROCARDIOGRAM (EKG)	10.70*	10.70*	10.70*	12.80*	10.70*	10.00	12.40	10.70*	10.70*	10.70*	10.70*	10.70*	10.70*	10.70*	034
035	EKG INTERPRET-REPORT ONLY						27.40*	29.00*	68.60	68.60	57.40	57.40	57.40	57.40	57.40	035
036	ARTERIAL BLOOD GAS STUDY						57.00*	53.50*	49.90*	49.90*	53.50*	53.50*	53.50*	53.50*	53.50*	036
037	ELECTROENCEPHALOGRAPH (EEG)						17.40*	22.10*	13.00	13.00	15.35*	15.35*	15.35*	15.35*	15.35*	037
038	CHEMOTHERAPY						3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	038
039	COLLECTION OF SPECIMENS						12.50	12.50	12.50	12.50	18.20	18.20	18.20	18.20	18.20	039
040	DEBRIDEMENT OF NAILS						30.00	23.65*	26.20*	26.20*	23.65*	23.65*	23.65*	23.65*	23.65*	040
041	SKIN BIOPSY						19.00	17.70*	17.10*	17.10*	19.00	19.00	19.00	19.00	19.00	041
042	CHEMOCAUTERY						713.00*	684.50*	570.40*	570.40*	598.90*	598.90*	598.90*	598.90*	598.90*	042
043	RADICAL MASTECTOMY						792.60*	798.60*	648.90*	648.90*	798.60*	798.60*	798.60*	798.60*	798.60*	043
044	OPEN REDUCTION OF FRACTURE						25.70*	20.00	25.00	25.00	22.00	22.00	22.00	22.00	22.00	044
045	ARTHROCENTESIS-MAJOR JOINT						21.30*	21.30*	17.10*	17.10*	22.00	22.00	22.00	22.00	22.00	045
046	ARTHROTOMY						1312.50*	1040.00	798.60*	798.60*	821.10*	821.10*	821.10*	821.10*	821.10*	046
047	ARTHROPLASTY-REPAIR OF HIP						21.30*	17.40*	17.40*	17.40*	17.40*	17.40*	17.40*	17.40*	17.40*	047
048	NEEDLE PUNCTURE OF BURSA						142.60*	130.50*	121.30*	121.30*	142.60*	142.60*	142.60*	142.60*	142.60*	048
049	BRONCHOSCOPY						30.00*	26.20*	26.20*	26.20*	25.70*	25.70*	25.70*	25.70*	25.70*	049
050	THORACENTESIS															050

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	02	03	12	99	01	02	03	12	99
051 CATHETERIZATION OF HEART						400.00	400.00	351.00	400.00	397.90*
052 INSERTION OF PACEMAKER						440.00	660.00*	790.00	727.70*	800.00
053 PERITONEAL COLLECTION						741.40*	695.80*	641.70*	664.50*	684.50*
054 APPENDICECTOMY						360.00*	380.00	356.50*	347.90*	356.50*
055 SIGMOIDECTOMY						25.70*	28.00	28.50*	24.00	25.00
056 HEMORRHOIDECTOMY					25.00	315.00	260.90*	235.30*	260.90*	315.00
057 CHOLECYSTECTOMY						570.40*	600.00	499.10*	568.60*	537.60*
058 VAGINAL HERNIA						350.50*	356.50*	285.20*	299.50*	333.70*
059 DIAGNOSTIC CYSTOURETHROSCOPY						71.40*	49.90*	56.60*	48.00	68.50*
060 DILATION OF URETHRA						27.90*	21.00	16.00	17.25	21.30*
061 PROSTATECTOMY						684.50*	627.30*	684.50*	641.70*	684.50*
062 ELECTROSECTION-PROSTATE (TUR)					688.00	741.40*	627.30*	627.30*	684.50*	684.50*
063 HYSTERECTOMY						541.70*	684.50*	530.60*	608.90*	570.40*
064 INITIAL COMPLETE EYE EXAM						28.00	28.50*	22.80*	25.70*	27.00
065 COMPREHENSIVE EYE EXAM						28.00*	29.10*	25.00*	23.40*	29.10*
066 EYE EXAM WITH TOMOMETRY						11.40*	11.40*	11.40*	10.00	10.70*
067 EXTRACTION OF LENS						713.00*	700.00	713.00*	684.50*	677.40*
068 CHEST X-RAY, SINGLE VIEW						14.30*	15.70*	19.50	15.70*	15.70*
069 CHEST X-RAY, TWO VIEWS					22.80*	23.50*	23.50*	25.70*	23.50*	24.00
070 X-RAY SPINE						25.70*	23.60*	28.50*	28.50*	28.00
071 X-RAY HIP						25.70*	27.00*	25.70*	25.70*	28.50*
072 X-RAY UPPER GI TRACT						49.90*	47.10*	54.20*	46.30*	57.00*
073 X-RAY PELVIS						49.90*	41.30*	54.20*	41.30*	49.90*
074 RADIATION THERAPY-LOW VOLT						23.50*	21.90	20.40	24.00	21.30*
075 RADIATION THERAPY-SUPER VOLT						30.00	18.00	18.00	18.00	33.20
076 RADIATION THERAPY-MESAVOLT						29.20	29.20	27.20	32.00	33.20
077 CAT SCAN - HEAD						209.00	209.00	209.00	209.00	209.00
078 CAT SCAN-HEAD, INTERPRET ONLY						35.00	35.00	35.00	35.00	35.00
079 THREE CHEMISTRY TESTS						16.00	18.90	17.00	17.50	14.00
080 TWELVE CHEMISTRY TESTS						17.00	33.00	23.50	14.50	11.95
081 CULTURE-OTHER THAN BLOOD						11.50	11.50	11.50	8.00	10.00
082 HEMOGLOBIN						4.00	5.00	3.50	4.00	4.00
083 DIFFERENTIAL BLOOD COUNT						10.00	5.85	5.00	10.75	11.00
084 WHITE CELL COUNT						3.50	5.00	3.20	3.84	4.00
085 COMPLETE BLOOD COUNT (CBC)						8.50	12.40	10.00	10.25	10.05
086 CHOLESTEROL TEST						7.50	11.00	8.50	9.00	8.75
087 FLOCCULATION TEST						5.55	7.00	5.00	5.55	4.00
088 HEVATOCRIT						4.00	4.25	3.20	5.00	4.00
089 PLATELET COUNT (REES-ECKER)						5.00	8.00	8.00	7.70	6.00
090 POTASSIUM TEST						7.00	14.00	7.50	9.50	9.00
091 PROTHROMBIN						6.50	8.30	6.50	7.61	8.00
092 SEDIMENTATION RATE						4.00	5.10	3.50	5.60	6.00
093 BUN-UREA, NITROGEN						7.00	10.70	7.00	8.50	8.00
094 URIC ACID						7.50	11.50	8.50	9.00	9.20
095 FECES-OCCULT BLOOD						3.50	4.00	3.50	8.60	8.00
096 PAP TEST						8.50	10.00	6.50	5.00	4.00
097 ROUTINE URINALYSIS						5.00	6.50	5.00	10.00	10.00
098 CHEMICAL URINALYSIS						4.00	3.21	2.04	5.00	5.00
100 PATHOLOGY-THREE SPECIMENS						18.00	24.75	24.00	2.79	30.00

PENNSYLVANIA

11 - Areas of Medical Schools/Specialty Hospitals

- 1 - Areas of Medical Schools/
- 2 - Major Metropolitan Areas
- 3 - Lesser Metropolitan Areas
- 4 - Urban Areas

Note exceptions for Pittsburgh and Philadelphia in Appendix A

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

1 2 3 4

001 INITIAL BRIEF OFFICE VISIT	12.00	12.00	10.00	10.00	15.00	14.30*	14.00	10.00	001
002 INITIAL LIMITED OFFICE VISIT				10.00	20.00	16.00	15.00	12.00	002
003 INIT INTERMED OFFICE VISIT	35.00	36.00	25.00	20.00	20.00	16.00	15.00	12.00	003
004 INIT COMP OFFICE VISIT					50.00	50.00	45.00	40.00	004
005 MINIMAL F/U OFFICE VISIT									005
006 BRIEF F/U OFFICE VISIT	10.00	10.00	10.00*	10.00	15.00	14.30*	14.00	10.00	006
007 LIMITED F/U OFFICE VISIT	12.00	12.00	10.00	10.00	20.00	16.00	15.00	12.00	007
008 INTERMED F/U OFFICE VISIT	12.00	12.00	10.00	10.00	20.00	16.00	15.00	12.00	008
009 EXTENDED F/U OFFICE VISIT	12.00	18.00	15.00	12.00	35.00	40.00	8.00	20.00	009
010 COMPLETE F/U OFFICE VISIT	35.00	36.00	25.00	20.00	50.00	50.00	45.00	40.00	010
011 BRIEF F/U HOME VISIT	14.30*	14.30*	13.00	12.00	12.00	14.30*	14.30*	12.00	011
012 LIMITED F/U HOME VISIT					17.10*	17.10*	14.30*	14.30*	012
013 INTERMEDIATE F/U HOME VISIT	15.00	17.10*	14.30*	14.30*	17.10*	17.10*	14.30*	14.30*	013
014 EXTENDED CARE FACILITY VISIT					14.30*	12.00	14.30*	10.00	014
015 BRIEF F/U NURSING HOME VISIT	14.30	12.00	9.00	10.00	11.00	14.30*	10.00	10.00	015
016 INITIAL BRIEF HOSPITAL VISIT	42.80*	35.00	28.50*	25.00	49.90*	42.80*	42.80*	35.00	016
017 INIT INTERMED HOSPITAL VISIT					20.00	18.00	15.00	15.00	017
018 INITIAL COMP HOSPITAL VISIT	49.90*	40.00	40.00	40.00	60.00	60.00	49.90*	49.90*	018
019 BRIEF F/U HOSPITAL VISIT	14.00	10.00	10.00	10.00	17.00	14.30*	14.30*	10.00	019
020 LIMITED F/U HOSPITAL VISIT	15.00	14.30*	14.30*	10.00	20.00	18.00	15.00	15.00	020
021 INTERMED F/U HOSPITAL VISIT	15.00	14.30*	14.30*	10.00	20.00	18.00	15.00	15.00	021
022 EXTENDED F/U HOSPITAL VISIT					40.00	49.90*	35.70*	30.00	022
023 BRIEF EMERGENCY ROOM VISIT					15.00	14.30*	14.00	10.00	023
024 LIMITED EMERGENCY ROOM VISIT					20.00	16.00	15.00	12.00	024
025 INTERMED EMERGENCY ROOM VISIT					20.00	15.00	15.00	12.00	025
026 LIMITED CONSULTATION	35.00	30.00	28.50*	25.00	45.00	40.00	35.70*	35.00	026
027 EXTENSIVE CONSULTATION					45.00	40.00	35.70*	35.00	027
028 COMPREHENSIVE CONSULTATION					71.30*	60.00	57.00*	50.00	028
029 PSYCHOTHERAPY-ONE HOUR					50.00	45.00	35.00	15.00	029
030 PSYCHOTHERAPY-HALF HOUR					30.00	30.00	25.00	15.00	030
031 CHIROPRACTIC OFFICE VISIT	9.40*	13.00*	8.70*	9.00	11.80*	9.60*	8.00*	8.00	031
032 INITIAL PHYSIOTHERAPY					20.00	15.00	20.00	20.00	032
033 F/U PODIATRIC OFFICE VISIT					13.00	12.00	11.40*	10.00*	033
034 ELECTROCARDIOGRAM (EKG)	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	034
035 ECG-INTERPRET, REPORT ONLY	20.00	20.00	14.30*	20.00	20.00	8.00	14.30*	15.00	035
036 ARTERIAL BLOOD GAS STUDY					35.00	15.00	20.00	20.00	036
037 ELECTROENCEPHALOGRAPH (EEG)					49.90*	49.90*	49.90	49.90*	037
038 CHEMOTHERAPY									038
039 COLLECTION OF SPECIMENS									039
040 DEBRIDEMENT OF NAILS					21.40*	20.00	21.40*	15.00	040
041 SKIN BIOPSY					40.00	30.00	30.00	30.00	041
042 CHEMOCAUTERY					35.00	30.00	40.20*	35.00	042
043 RADICAL MASTECTOMY					713.00	713.00*	570.40*	500.00	043
044 OPEN REDUCTION OF FRACTURE					950.00	855.60*	613.20*	713.00*	044
045 ARTHROCENTESIS-MAJOR JOINT					25.00	25.00	25.00	20.00	045
046 ARTHROTOMY					17.70*	20.00	17.25*	15.00	046
047 ARTHROPLASTY-REPAIR OF HIP				18.25*	1200.00	1200.00	1200.00	1200.00	047
048 NEEDLE PUNCTURE OF BURSA					25.00	25.00	25.00	30.00	048
049 BRONCHOSCOPY					142.60*	142.60*	142.60*	125.00	049
050 THORACENTESIS					85.00	71.30*	71.30*	70.00	050

1979 PREVAILING CHARGE SUMMARY DATA PENNSYLVANIA B/S

PENNSYLVANIA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	1	2	3	4	1	2	3	4
051 CATHETERIZATION OF HEART					350.00	300.00	356.50	350.00
052 INSERTION OF PACEMAKER					800.00	763.00	900.00	750.00
053 PARTIAL COLECTOMY					900.00	850.00	713.00*	675.00
054 APPENDECTOMY					350.50*	320.90*	289.50*	265.20*
055 SIGMOIDOSCOPY					45.00	35.70*	35.70*	40.00
056 HEMORRHOIDECTOMY				35.00	285.20*	285.20*	235.30*	249.60*
057 CHOLECYSTECTOMY					570.40*	570.40*	499.10*	470.60*
058 REPAIR HERNIA					356.50*	356.50*	285.20*	285.20*
059 DIAGNOSTIC CYSTOURETHROSCOPY					50.00	65.00	58.00	60.00
060 DILATION OF URETHRA				50.00	21.40*	20.00	14.30*	10.00
061 PROSTATECTOMY					713.00	713.00*	575.00	600.00
062 ELECTROSECTION-PROSTATE (TUR)				616.00	713.00	713.00*	627.40*	616.00
063 HYSTERECTOMY					641.70*	641.70*	570.40*	570.40*
064 INITIAL COMPLETE EYE EXAM								
065 COMPREHENSIVE EYE EXAM					6.00	10.00	12.00*	12.10*
066 EYE EXAM WITH TOMOMETRY					700.00	641.70*	641.70*	641.70*
067 EXTRACTION OF LENS				606.10*	20.00	28.50*	15.00	15.00
068 CHEST X-RAY, SINGLE VIEW				25.00	30.00	30.00	25.00	23.00
069 CHEST X-RAY, TWO VIEWS				32.00	40.00	42.00	45.00	35.00
070 X-RAY SPINE					25.50*	25.00	25.00	21.40*
071 X-RAY HIP					66.00	64.20*	57.00*	49.90*
072 X-RAY UPPER GI TRACT				50.00	60.00	49.90*	49.90*	49.90*
073 X-RAY COLON					35.00	15.00	25.00	20.00
074 RADIATION THERAPY-LOW VOLT				20.00	30.00*	30.00	38.00	23.00*
075 RADIATION THERAPY-SUPER VOLT				25.40*	31.10*	39.10*	30.00	34.60
076 RADIATION THERAPY-MEGAVOLT					135.00	135.00	135.00	135.00
077 CAT SCAN - HEAD					75.00	75.00	75.00	75.00
078 CAT SCAN-HEAD, INTERPRET ONLY					9.50	9.50	9.50	9.50
079 THREE CHEMISTRY TESTS					14.30	14.30	14.30	14.30
080 TWELVE CHEMISTRY TESTS					10.00	7.00	5.00	15.00
081 CULTURE-OTHER THAN BLOOD					3.00	3.00	5.00	3.00
082 HEMOGLOBIN					10.00	7.50	7.00	7.00
083 AUTOMATED BLOOD COUNT					2.00	3.00	2.50	3.00
084 WHITE CELL COUNT					8.00	8.00	7.00	7.00
085 COMPLETE BLOOD COUNT (CBC)					6.00	7.00	6.00	5.00
086 CHOLESTEROL TEST					4.00	3.00	3.00	2.50
087 FLOCCULATION TEST					6.00	5.50	6.00	5.00
088 HEMATOCRIT					4.00	3.00	3.00	2.50
089 PLATELET COUNT (REES-ECKER)					6.00	6.00	7.00	4.00
090 POTASSIUM TEST					8.00	8.00	7.00	5.50
091 PROTHROMBIN					6.00	6.00	5.00	5.00
092 SEDIMENTATION RATE					5.00	5.20	5.00	4.00
093 BLOOD SUGAR					6.00	6.00	5.00	5.00
094 BUN-UREA, NITROGEN					7.00	6.00	6.00	6.00
095 URIC ACID					8.00	7.00	6.00	6.00
096 FECES-OCCULT BLOOD					5.00	5.00	4.00	3.50
097 PAP TEST					7.00	8.00	10.00	6.00
098 ROUTINE URINALYSIS					5.00	5.00	5.00	3.50
099 CHEMICAL URINALYSIS					5.50	5.00	4.00	3.00
100 PATHOLOGY-THREE SPECIMENS					20.00	20.00	15.00	17.00

PUERTO RICO

PUERTO RICO

San Juan, Hato Rey, Santurce, &
Rio Piedras
01



PUERTO RICO

Four Localities:

- 01 Cities of San Juan, Hato Rey, Santurce, Rio Piedras
(San Juan Metropolitan area)
- 02 Cities of Ponce, Mayaguez, San German, Bayamon, Caguas, Guayama
- 03 Cities of Arecibo, Humacao, Aguadilla, Fajardo, Carolina
and Guaynabo
- 04 The rest of the towns in Puerto Rico

(Locality is determined by the city cited in the
return address)

VIRGIN ISLANDS

One Locality - Too small for separate screens. Handled by the
Puerto Rico carrier.

1979 PREVAILING CHARGE SUMMARY DATA

SEGUROS DE SERVICIO DE SALUD PR.

PUERTO RICO

LOCALITY DESIGNATION FOR GENERAL PRACTICE

PROCEDURE DESCRIPTION

AREA 1 AREA 2 AREA 3 AREA 4

LOCALITY DESIGNATION FOR SPECIALIST

AREA 1 AREA 2 AREA 3 AREA 4

001 INITIAL BRIEF OFFICE VISIT	14.30	15.00	10.00	10.00	15.00	14.30	14.30	14.30	001
002 INITIAL LIMITED OFFICE VISIT					33.50	28.50	25.00	28.50	002
003 INIT INTERMED OFFICE VISIT	14.30	15.00	10.00	10.00	33.50	28.50	25.00	28.50	003
004 INIT COMP OFFICE VISIT									004
005 MINIMAL F/U OFFICE VISIT	12.00	10.00	10.00	10.00	15.00	14.30	14.30	14.30	005
006 BRIEF F/U OFFICE VISIT	12.00	10.00	10.00	10.00	20.00	14.30	14.30	14.30	006
007 LIMITED F/U OFFICE VISIT	12.00	10.00	10.00	10.00	20.00	20.00	20.00	15.00	007
008 INTERMED F/U OFFICE VISIT									008
009 EXTENDED F/U OFFICE VISIT									009
010 COMPLETE F/U OFFICE VISIT									010
011 BRIEF F/U HOME VISIT	21.30	15.00	14.30	14.30	15.00	15.00	20.00	9.20	011
012 LIMITED F/U HOME VISIT					15.00	15.00	20.00	9.20	012
013 INTERMEDIATE F/U HOME VISIT	21.30	15.00	14.30	14.30	15.00	15.00	20.00	9.20	013
014 EXTENDED CARE FACILITY VISIT					15.00	15.00	10.00	10.00	014
015 BRIEF F/U NURSING HOME VISIT	15.00	15.00	15.00	15.00	15.00	15.00	15.00	15.00	015
016 INITIAL BRIEF HOSPITAL VISIT	25.00	28.50	15.00	15.00	35.00	28.50	25.00	25.00	016
017 INIT INTERMED HOSPITAL VISIT					35.00	28.50	25.00	25.00	017
018 INITIAL COMP HOSPITAL VISIT	25.00	20.00	30.00	25.00	35.00	26.00	26.30	25.00	018
019 BRIEF F/U HOSPITAL VISIT	14.30	13.00	10.00	10.00	14.30	14.30	14.30	14.30	019
020 LIMITED F/U HOSPITAL VISIT	14.30	8.20*	7.80	25.00	25.00*	20.00	13.60	13.00	020
021 INTERMED F/U HOSPITAL VISIT	25.00	25.00	25.00	25.00	43.90	25.00	25.00	25.00	021
022 EXTENDED F/U HOSPITAL VISIT					43.90	14.30	14.30	14.30	022
023 BRIEF EMERGENCY ROOM VISIT					24.40	25.00	15.00	15.00	023
024 LIMITED EMERGENCY ROOM VISIT					24.40	25.00	15.00	15.00	024
025 INTERMED EMERGENCY ROOM VISIT					24.40	25.00	15.00	15.00	025
026 LIMITED CONSULTATION	14.30	13.00	10.00		25.70	25.70	25.00	21.00	026
027 EXTENSIVE CONSULTATION					20.00*	28.40	28.00	28.00	027
028 COMPREHENSIVE CONSULTATION					33.50*	35.00	35.00	35.00	028
029 PSYCHOTHERAPY-ONE HOUR					33.50*	35.60	25.00*	25.00	029
030 PSYCHOTHERAPY-HALF HOUR					33.50	35.60	25.00*	25.00	030
031 CHIROPRACTIC OFFICE VISIT	15.00	10.00	10.00		10.00	10.00	10.00	10.00	031
032 INITIAL PHYSIOTHERAPY					25.00	25.00	25.00	26.50	032
033 F/U PODIATRIC OFFICE VISIT					15.00	15.00	15.00	15.00	033
034 ELECTROCARDIOGRAM (ECG)	25.00	30.00	20.00	25.00	30.00	28.50	28.50	25.00	034
035 EKG-INTERPRET, REPORT ONLY	20.00	26.00	15.00	15.00	20.00	20.00	20.00	15.00	035
036 ARTERIAL BLOOD GAS STUDY					35.00	35.00	35.00	11.70	036
037 ELECTROENCEPHALOGRAM (EEG)					45.00	40.00	40.00*	39.90	037
038 CHEMOTHERAPY					20.00	20.00	20.00	20.00	038
039 COLLECTION OF SPECIMENS									039
040 DEBRIDEMENT OF NAILS					23.00	18.00	18.00	18.20	040
041 SKIN BIOPSY					34.50	27.00	27.00	27.30	041
042 CHEMOCAUTERY					13.00	15.00	18.00	27.30	042
043 RADICAL MASTECTOMY					850.00	850.00	600.00	637.00	043
044 OPEN REDUCTION OF FRACTURE					1120.00	1090.00	872.00	872.00	044
045 ARTHROCENTESIS-MAJOR JOINT					35.20	35.90	32.70	36.90	045
046 ARTHROTOMY	30.00	20.00	20.00	20.00	35.20	23.10	21.80	23.10*	046
047 ARTHROPLASTY-REPAIR OF HIP					1120.00	1090.00	1090.00	1090.00	047
048 NEEDLE PUNCTURE OF BURSA					23.00	18.00	18.00	27.30	048
049 BRONCHOSCOPY					172.50	135.00	135.00	136.50	049
050 THORACENTESIS					47.80	27.00	27.00	36.40	050

1979 PREVAILING CHARGE SUMMARY DATA SEGUROS DE SERVICIO DE SALUD PR. PUERTO RICO

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

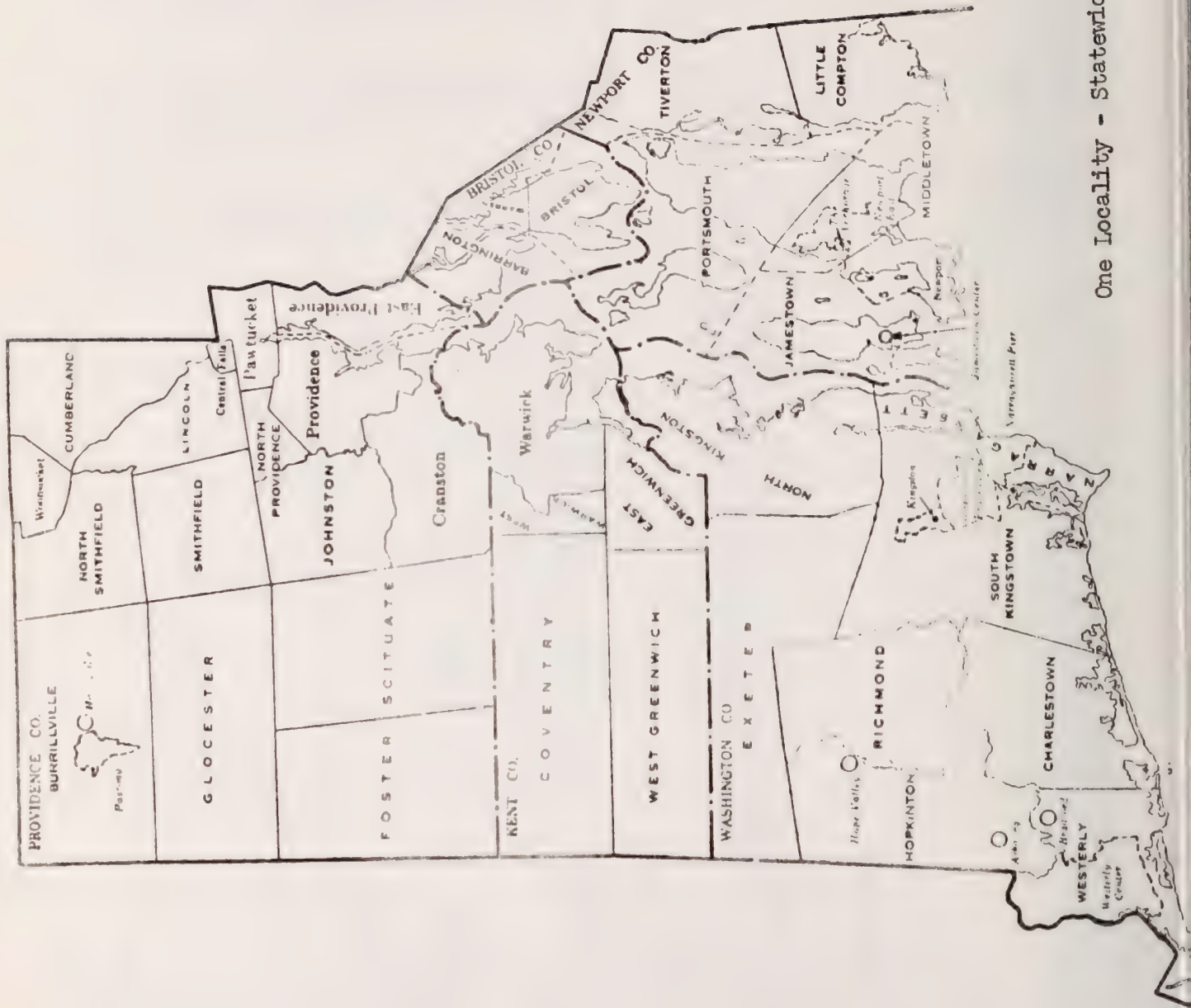
AREA 1 AREA 2 AREA 3 AREA 4

AREA 1 AREA 2 AREA 3 AREA 4

C51 CATHETERIZATION OF HEART	343.00	405.00	405.00	405.00	405.00*	051
C52 INSERTION OF PACEMAKER	980.00	900.00	900.00	900.00	900.00*	052
C53 PARTIAL COLECTOMY	1000.00	713.00	720.00	720.00	723.00	053
C54 APENDICECTOMY	350.00	300.00	280.00	280.00	283.50	054
C55 BIL. ILEOSTOMY	30.00*	20.00	27.00	27.00	27.30	055
C56 REVERSED ILEOSTOMY	320.80	300.00	270.00	270.00	273.00	056
C57 CHOLECYSTECTOMY	684.50	570.40	570.40	570.40	570.40	057
C58 REPAIR HERNIA	427.80	349.40	285.20	285.20	350.00	058
C59 DIAGNOSTIC CYSTOURETHROSCOPY	81.50	50.00	50.00	50.00	50.00	059
C60 DILATION OF URETHRA	55.90	49.90	29.70	29.70	29.70	060
C61 PROSTATECTOMY	51.50	45.50	792.00	792.00	792.00	061
C62 ELECTRORESECTION-PROSTATE (TUR)	1504.00	800.00	800.00	800.00	702.00	062
C63 HYSTERECTOMY	880.00	800.00	570.40	570.40	707.00	063
C64 INITIAL COMPLETE EYE EXAM	20.00	20.00	15.00	15.00	15.00*	064
C65 COMPREHENSIVE EYE EXAM	20.00	20.00	15.00	15.00	15.00*	065
C66 EYE EXAM WITH TONOMETRY	34.20	14.20	17.60	17.60	21.30	066
C67 EXTRACTION OF LENS	1504.00	800.00	800.00	800.00	704.00	067
C68 CHEST X-RAY, SINGLE VIEW	11.50	11.50	11.50	11.50	11.50	068
C69 CHEST X-RAY, TWO VIEWS	17.25	17.25	17.25	17.25	19.20	069
C70 X-RAY SPINE					25.00	070
C71 X-RAY HIP					25.00	071
C72 X-RAY UPPER GI TRACT	57.50	57.50	57.50	57.50	20.00	072
C73 X-RAY COLON					20.00	073
C74 RADIATION THERAPY-LOW VOLT	18.60	20.00	20.00	20.00	28.00	074
C75 RADIATION THERAPY-SUPER VOLT	24.80	40.00	40.00	40.00	20.00	075
C76 RADIATION THERAPY-MEGAVOLT					40.00	076
C77 CAT SCAN - HEAD					150.00	077
C78 CAT SCAN-HEAD, INTERPRET ONLY					150.00	078
C79 THREE CHEMISTRY TESTS	30.00	30.00	30.00	30.00	30.00	079
C80 TWELVE CHEMISTRY TESTS	15.00	15.00	15.00	15.00	15.00	080
C81 CULTURE-OTHER THAN BLOOD	3.00	3.00	3.00	3.00	3.00	081
C82 HEMOGLOBIN					3.00	082
C83 AUTOMATED BLOOD COUNT						083
C84 WHITE CELL COUNT	2.00	2.00	2.00	2.00	2.00	084
C85 COMPLETE BLOOD COUNT (CBC)	8.00	8.00	8.00	8.00	8.00	085
C86 CHOLESTEROL TEST	10.00	10.00	10.00	10.00	10.00	086
C87 FLOCCULATION TEST						087
C88 HEMATOCRIT	3.00	3.00	3.00	3.00	3.00	088
C89 PLATELET COUNT (REES-ECKER)	6.00	6.00	6.00	6.00	6.00	089
C90 POTASSIUM TEST	12.00	12.00	12.00	12.00	12.00	090
C91 PROTHROMBIN	7.00	7.00	7.00	7.00	7.00	091
C92 SEDIMENTATION RATE	7.00	7.00	7.00	7.00	7.00	092
C93 BLOOD SUGAR	7.00	7.00	7.00	7.00	7.00	093
C94 SURENITROGEN	8.00	8.00	8.00	8.00	8.00	094
C95 URIC ACID	8.00	8.00	8.00	8.00	8.00	095
C96 FECES-OCCULT BLOOD	5.00	5.00	5.00	5.00	5.00	096
C97 PAP TEST	8.00	8.00	8.00	8.00	8.00	097
C98 ROUTINE URINALYSIS	5.00	5.00	5.00	5.00	5.00	098
C99 CHEMICAL URINALYSIS	5.00	5.00	5.00	5.00	5.00	099
C100 PATHOLOGY-THREE SPECIMENS	20.00	25.00	25.00	25.00	20.00	100

RHODE ISLAND

RHODE ISLAND



One Locality - Statewide

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

SINGLE

SINGLE

001 INITIAL BRIEF OFFICE VISIT	20.00*	29.48	001
002 INITIAL LIMITED OFFICE VISIT		49.91*	002
003 INIT INTERMED OFFICE VISIT		29.48	003
004 INIT COMP OFFICE VISIT	15.00	49.91*	004
005 MINIMAL F/U OFFICE VISIT	12.97	12.00	005
006 BRIEF F/U OFFICE VISIT	11.40*	14.26*	006
007 LIMITED F/U OFFICE VISIT	14.26*	21.39*	007
008 INTERMED F/U OFFICE VISIT	14.26*	21.39*	008
009 EXTENDED F/U OFFICE VISIT	15.00	21.39*	009
010 COMPLETE F/U OFFICE VISIT	25.00	35.65*	010
011 BRIEF F/U HOME VISIT	17.11*	21.39*	011
012 LIMITED F/U HOME VISIT		20.00*	012
013 INTERMEDIATE F/U HOME VISIT	15.00	20.00*	013
014 EXTENDED CARE FACILITY VISIT		21.39*	014
015 BRIEF F/U NURSING HOME VISIT	11.40	14.26*	015
016 INITIAL BRIEF HOSPITAL VISIT	30.00	50.00	016
017 INIT INTERMED HOSPITAL VISIT		49.91*	017
018 INITIAL COMP HOSPITAL VISIT	35.65*	50.00	018
019 BRIEF F/U HOSPITAL VISIT	15.00	14.26*	019
020 LIMITED F/U HOSPITAL VISIT	20.00	25.00	020
021 INTERMED F/U HOSPITAL VISIT	20.00	20.00	021
022 EXTENDED F/U HOSPITAL VISIT		20.00	022
023 BRIEF EMERGENCY ROOM VISIT			023
024 LIMITED EMERGENCY ROOM VISIT			024
025 INTERMED EMERGENCY ROOM VISIT			025
026 LIMITED CONSULTATION	35.65*	30.00	026
027 EXTENSIVE CONSULTATION		49.91*	027
028 COMPREHENSIVE CONSULTATION		58.95	028
029 PSYCHOTHERAPY-ONE HOUR		49.91*	029
030 PSYCHOTHERAPY-HALF HOUR		28.52*	030
031 CHIROPRACTIC OFFICE VISIT	10.88*	10.88*	031
032 INITIAL PHYSIOTHERAPY		21.39*	032
033 F/U PODIATRIC OFFICE VISIT		14.26*	033
034 ELECTROCARDIOGRAM (EKG)	25.00	25.00	034
035 EKG-INTERPRET-REPORT ONLY	10.00	15.00	035
036 ARTERIAL BLOOD GAS STUDY			036
037 ELECTROENCEPHALOGRAPH (EEG)		45.00	037
038 CHEMOTHERAPY			038
039 COLLECTION OF SPECIMENS		5.00	039
040 DEBRIDEMENT OF NAILS		21.01*	040
041 SKIN BIOPSY		35.00	041
042 CHEMOCAUTERY		35.00	042
043 FINGER FINGERECTOMY		750.00	043
044 OPEN REDUCTION OF FRACTURE		748.65*	044
045 ARTHROCENTESIS-MAJOR JOINT		29.48	045
046 ARTHROTOMY		29.48	046
047 ARTHROPLASTY-REPAIR OF HIP	21.39*	855.60*	047
048 NEEDLE PUNCTURE OF BURSA		21.39*	048
049 BRONCHOSCOPY		200.00	049
050 THORACENTESIS		42.78*	050

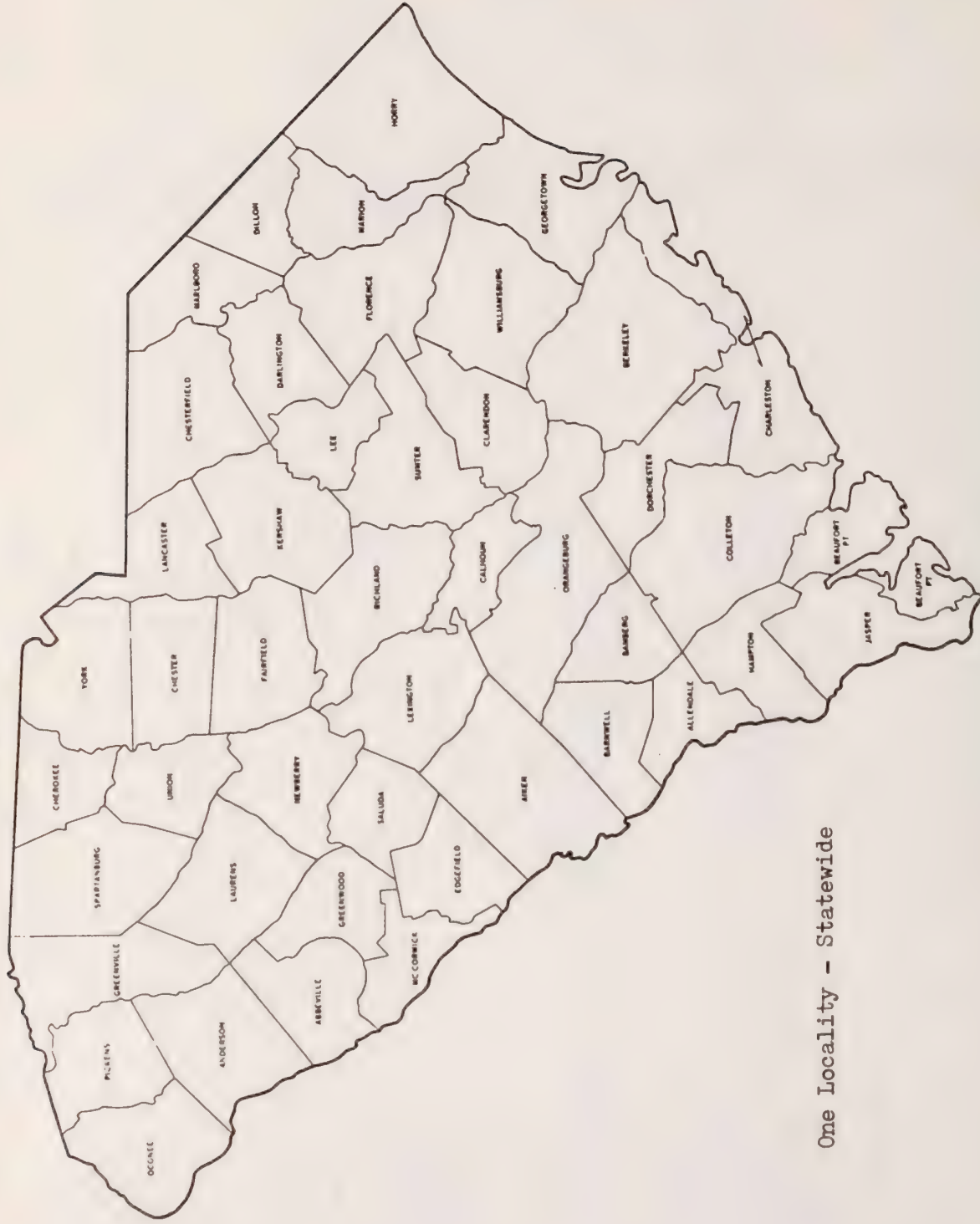
1979 PREVAILING CHARGE SUMMARY DATA B/S OF RHODE ISLAND RHODE ISLAND

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	SINGLE	SINGLE
051 CATHETERIZATION OF HEART		392.15*
052 INSERTION OF PACEMAKER		424.94*
053 PARTIAL COLECTOMY		905.00
054 AMPLECTOMY		356.50*
055 SCLEROTOMY	35.65*	41.27
056 SCLEROTOMY		300.00
057 HEMORRHOIDECTOMY		641.70*
058 CHOLECYSTECTOMY		356.50*
059 REPAIR HERNIA	71.30*	71.30*
060 DIAGNOSTIC CYSTOURETHROSCOPY		15.00
061 DILATION OF URETHRA		750.00
062 PROSTATECTOMY		641.70*
063 ELECTROSECTION-PROSTATE (TUR)	641.70*	650.00
064 HYSTECTOMY		21.39*
065 INITIAL COMPLETE EYE EXAM		21.39*
066 COMPREHENSIVE EYE EXAM		10.69*
067 EYE EXAM WITH TONOMETRY		641.70*
068 EXTRACTION OF LENS	641.70*	15.00
069 CHEST X-RAY, SINGLE VIEW	21.39*	21.39*
070 CHEST X-RAY, TWO VIEWS	21.39*	42.78*
071 X-RAY SPINE		17.11*
072 X-RAY HIP	49.91*	42.78*
073 X-RAY UPPER GI TRACT		17.11*
074 X-RAY COLON		20.00
075 RADIATION THERAPY-LOW VOLT	17.11*	20.00
076 RADIATION THERAPY-SUPER VOLT	20.00	150.00
077 RADIATION THERAPY-MEGAVOLT		15.00
078 CAT SCAN - HEAD		12.00
079 CAT SCAN-HEAD, INTERPRET ONLY		7.00
080 THREE CHEMISTRY TESTS		4.00
081 TWELVE CHEMISTRY TESTS		8.00
082 CULTURE-OTHER THAN BLOOD		8.00
083 HEMOCLOSIN		8.00
084 AUTOTATED BLOOD COUNT		8.00
085 WHITE CELL COUNT		7.00
086 COMPLETE BLOOD COUNT (CBC)		6.00
087 CHOLESTEROL TEST		3.00
088 FLOCCULATION TEST		5.00
089 HEMATOCRIT		7.00
090 PLATELET COUNT (REES-ECKER)		6.00
091 POTASSIUM TEST		6.00
092 SODIUM TEST		5.00
093 URIC ACID		7.00
094 BUN-UREA, NITROGEN		7.00
095 URIC ACID		7.00
096 FECEES-OCULT BLOOD		4.00
097 PAP TEST		7.00
098 ROUTINE URINALYSIS		5.00
099 CHEMICAL URINALYSIS		3.00
100 PATHOLOGY-THREE SPECIMENS		20.00

SOUTH CAROLINA

SOUTH CAROLINA



One Locality - Statewide

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

SINGLE

SINGLE

001 INITIAL BRIEF OFFICE VISIT		10.00	001
002 INITIAL LIMITED OFFICE VISIT	7.96*	11.47*	002
003 INIT INTERMED OFFICE VISIT		20.19*	003
004 INIT COMP OFFICE VISIT	25.00	45.00	004
005 MINIMAL F/U OFFICE VISIT	7.96*	10.00	005
006 BRIEF F/U OFFICE VISIT	7.96*	10.00	006
007 LIMITED F/U OFFICE VISIT	7.96*	11.47*	007
008 INTERMED F/U OFFICE VISIT	15.00	20.19*	008
009 EXTENDED F/U OFFICE VISIT	15.00	15.00	009
010 COMPLETE F/U OFFICE VISIT	25.00		010
011 BRIEF F/U HOME VISIT	14.26*	14.26*	011
012 LIMITED F/U HOME VISIT		14.26*	012
013 INTERMEDIATE F/U HOME VISIT	18.97*	18.97*	013
014 EXTENDED CARE FACILITY VISIT		10.00	014
015 BRIEF F/U NURSING HOME VISIT	7.96*	11.47*	015
016 INITIAL BRIEF HOSPITAL VISIT	34.02*	33.00	016
017 INIT INTERMED HOSPITAL VISIT		25.00	017
018 INITIAL COMP HOSPITAL VISIT	35.00	49.91*	018
019 BRIEF F/U HOSPITAL VISIT	10.00	12.92*	019
020 LIMITED F/U HOSPITAL VISIT	10.00	12.92*	020
021 INTERMED F/U HOSPITAL VISIT	15.00	25.00	021
022 EXTENDED F/U HOSPITAL VISIT	15.00	25.00	022
023 BRIEF EMERGENCY ROOM VISIT		15.00	023
024 LIMITED EMERGENCY ROOM VISIT		25.00	024
025 INTERMED EMERGENCY ROOM VISIT	35.00	25.00	025
026 LIMITED CONSULTATION		33.84*	026
027 EXTENSIVE CONSULTATION		49.91*	027
028 COMPREHENSIVE CONSULTATION		49.91*	028
029 PSYCHOTHERAPY-ONE HOUR		37.95*	029
030 PSYCHOTHERAPY-HALF HOUR		25.30*	030
031 CHIROPRACTIC OFFICE VISIT	25.00	7.59*	031
032 INITIAL PHYSIOTHERAPY		30.00	032
033 F/U PODIATRIC OFFICE VISIT		12.00	033
034 ELECTROCARDIOGRAM (EKG)	18.97*	18.97*	034
035 EKG-INTERPRET, REPORT ONLY	5.00	10.00	035
036 ARTERIAL BLOOD GAS STUDY		25.00	036
037 ELECTROENCEPHALOGRAPH (EEG)		56.93*	037
038 CHEMOTHERAPY		30.00	038
039 COLLECTION OF SPECIMENS		3.00	039
040 DEBRIDEMENT OF NAILS		15.00	040
041 SKIN BIOPSY		28.52*	041
042 CHEMOCAUTERY			042
043 RADICAL MASTECTOMY		650.00	043
044 OPEN REDUCTION OF FRACTURE		598.92*	044
045 ARTHROCENTESIS-MAJOR JOINT		21.40*	045
046 ARTHROTOMY		21.00	046
047 ARTHROPLASTY-REPAIR OF HIP			047
048 NEEDLE PUNCTURE OF BURSA		23.79*	048
049 BRONCHOSCOPY		142.60*	049
050 THORACENTESIS		50.00	050

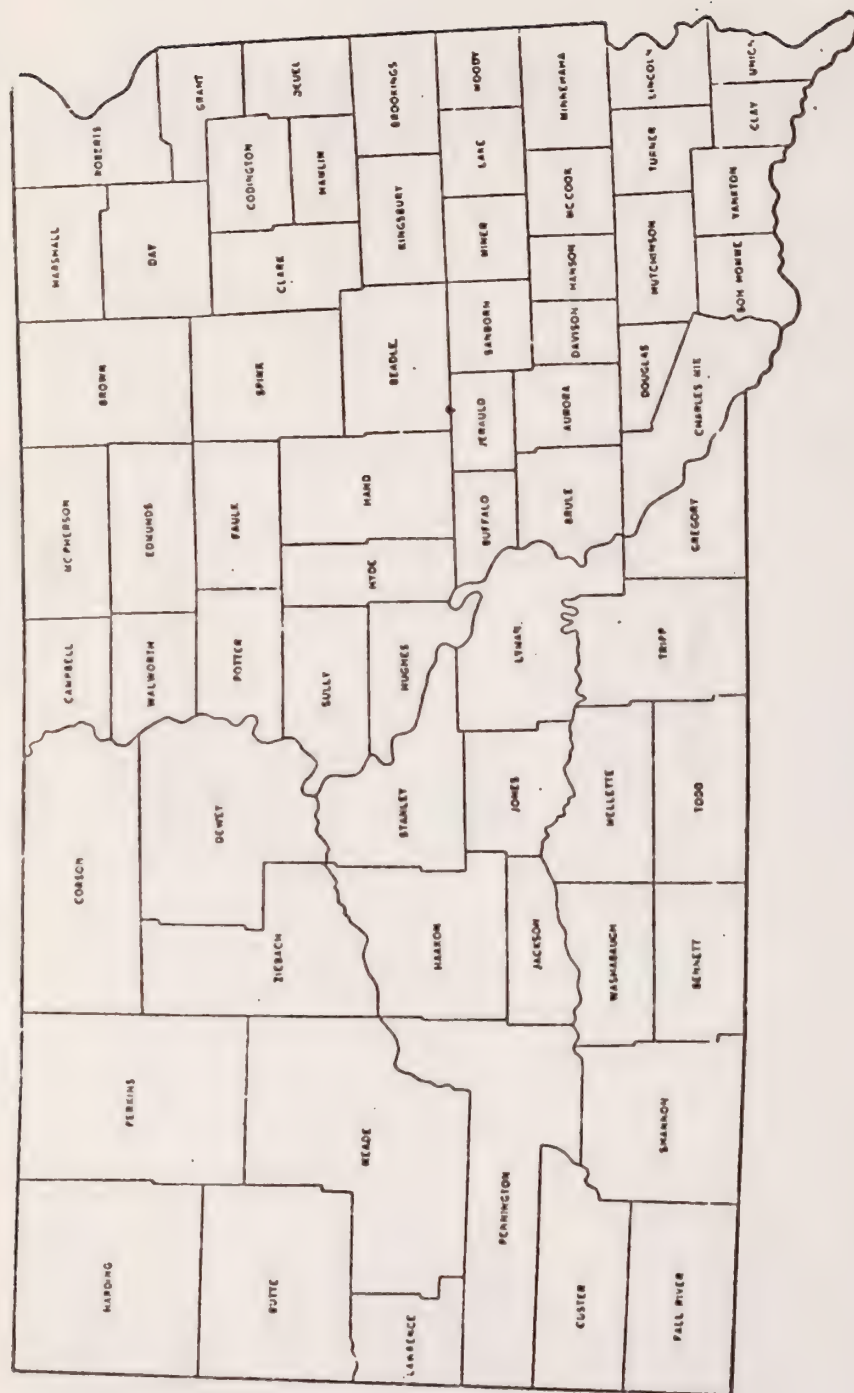
1979 PREVAILING CHARGE SUMMARY DATA B/C-B/S OF SOUTH CAROLINA SOUTH CAROLINA

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	SINGLE	SINGLE
051 CATHETERIZATION OF HEART		325.00
052 INSERTION OF PACEMAKER		800.00
053 PARTIAL COLECTOMY		750.00
054 APPENDECTOMY		304.78*
055 SIGMOIDOSCOPY	26.00*	34.69*
056 HEMORRHOIDECTOMY		280.74*
057 CHOLECYSTECTOMY		500.00
058 REPAIR HERNIA		321.72*
059 DIAGNOSTIC CYSTOURETHROSCOPY		60.00
060 DILATION OF URETHRA	60.00	17.50
061 PEDISTATECTOMY		684.48*
062 ELECTROSECTION-PROSTATE (TUR)	570.40*	570.40*
063 GYSTERECTOMY		570.40*
064 INITIAL COMPLETE EYE EXAM		30.00
065 COMPREHENSIVE EYE EXAM		30.00
066 EYE EXAM WITH TONOMETRY		10.00
067 EXTRACTION OF LENS		570.40*
068 CHEST X-RAY-SINGLE VIEW	570.40*	7.00
069 CHEST X-RAY-TWO VIEWS	15.00	10.00
070 X-RAY SPINE	20.00	16.46*
071 X-RAY HIP		11.75*
072 X-RAY UPPER GI TRACT	48.00	29.94*
073 X-RAY COLON		22.00
074 RADIATION THERAPY-LOW VOLT		11.00
075 RADIATION THERAPY-SUPER VOLT	11.00	15.00
076 RADIATION THERAPY-MEGAVOLT	15.00	50.00
077 CAT SCAN - HEAD		50.00
078 CAT SCAN-HEAD-INTERPRET ONLY		50.00
079 THREE CHEMISTRY TESTS		10.50
080 TWELVE CHEMISTRY TESTS		12.60
081 CULTURE-OTHER THAN BLOOD		8.00
082 HEMOGLOBIN		3.00
083 AUTOMATED BLOOD COUNT		4.00
084 WHITE CELL COUNT		3.00
085 COMPLETE BLOOD COUNT (CBC)		7.00
086 CHOLESTEROL TEST		5.00
087 FLOCCULATION TEST		5.00
088 HEMATOCRIT		3.50
089 PLATELET COUNT (REES-ECKER)		5.00
090 POTASSIUM TEST		6.00
091 PROTHROMBIN		5.00
092 SEDIMENTATION RATE		5.00
093 BLOOD SUGAR		6.00
094 BUN-UREA-NITROGEN		6.00
095 LACTIC ACID		6.00
096 FECES-OCULT BLOOD		3.00
097 PAP TEST		6.00
098 ROUTINE URINALYSIS		4.00
099 CHEMICAL URINALYSIS		3.00
100 PATHOLOGY-THREE SPECIMENS		

SOUTH DAKOTA

SOUTH DAKOTA



One Locality - Statewide

PROCEDURE DESCRIPTION

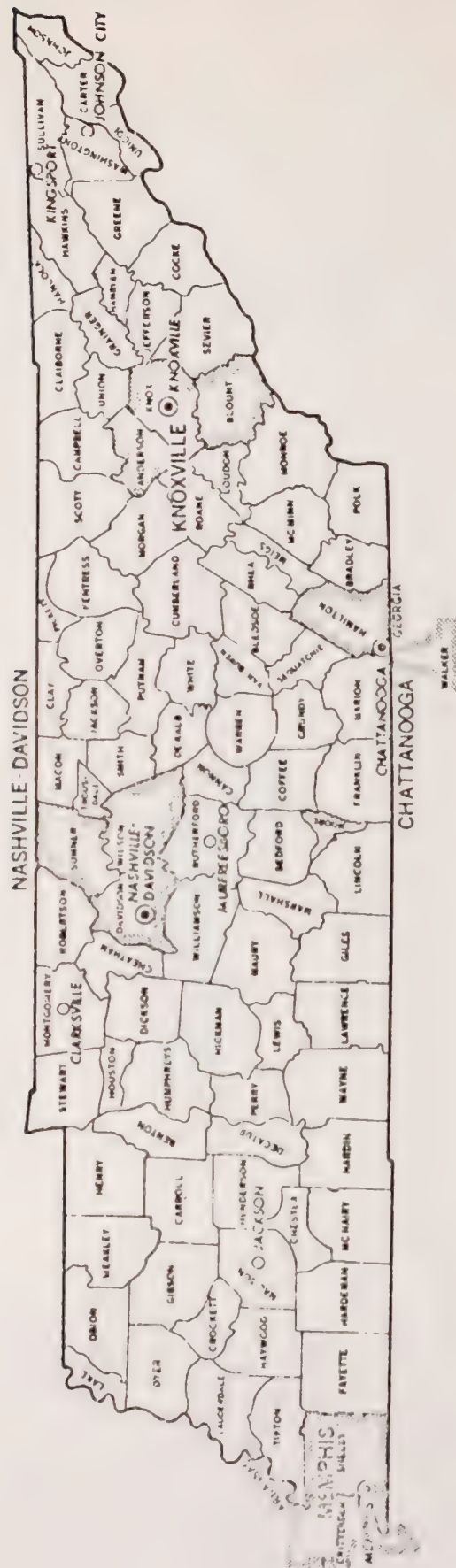
001	INITIAL BRIEF OFFICE VISIT	8.60*	001
002	INITIAL LIMITED OFFICE VISIT	15.00	002
003	INIT INTERMED OFFICE VISIT	15.00	003
004	INIT COMP OFFICE VISIT	35.00	004
005	MINIMAL F/U OFFICE VISIT	5.70*	005
006	BRIEF F/U OFFICE VISIT	8.60*	006
007	LIMITED F/U OFFICE VISIT	12.00	007
008	INTERMED F/U OFFICE VISIT	15.00	008
009	EXTENDED F/U OFFICE VISIT	20.00	009
010	COMPLETE F/U OFFICE VISIT	28.50*	010
011	BRIEF F/U HOME VISIT	14.00	011
012	LIMITED F/U HOME VISIT	15.00	012
013	INTERMDIATE F/U HOME VISIT	15.00	013
014	EXTENDED CARE FACILITY VISIT	14.00	014
015	BRIEF F/U NURSING HOME VISIT	8.60*	015
016	INITIAL BRIEF HOSPITAL VISIT	25.70*	016
017	INIT INTERMED HOSPITAL VISIT	49.90*	017
018	INITIAL COMP HOSPITAL VISIT	49.90*	018
019	BRIEF F/U HOSPITAL VISIT	8.60*	019
020	LIMITED F/U HOSPITAL VISIT	13.00	020
021	INTERMED F/U HOSPITAL VISIT	8.60*	021
022	EXTENDED F/U HOSPITAL VISIT	28.50*	022
023	BRIEF EMERGENCY ROOM VISIT	13.40*	023
024	LIMITED EMERGENCY ROOM VISIT	13.40*	024
025	INTERMED EMERGENCY ROOM VISIT	13.40*	025
026	LIMITED CONSULTATION	30.00*	026
027	EXTENSIVE CONSULTATION	35.60*	027
028	COMPREHENSIVE CONSULTATION	49.90*	028
029	PSYCHOTHERAPY-ONE HOUR	42.00	029
030	PSYCHOTHERAPY-HALF HOUR	20.00	030
031	CHIROPRACTIC OFFICE VISIT	9.00*	031
032	INITIAL PHYSICOTHERAPY		032
033	F/U PODIATRIC OFFICE VISIT	8.60*	033
034	ELECTROCARDIOGRAM (EKG)	20.50	034
035	EKG-INTERPRET-REPORT ONLY	12.80*	035
036	ARTERIAL BLOOD GAS STUDY	10.70*	036
037	ELECTROENCEPHALOGRAM (EEG)	64.10*	037
038	CHEMOTHERAPY	20.00	038
039	COLLECTION OF SPECIMENS	5.00	039
040	DEBRIDEMENT OF NAILS	14.30*	040
041	SKIN BIOPSY	14.30*	041
042	CHEMOCAUTERY	25.70*	042
043	RADICAL MASTECTOMY	14.30*	043
044	OPEN REDUCTION OF FRACTURE	597.60	044
045	ARTHROCENTESIS-MAJOR JOINT	570.60*	045
046	ARTHROTOMY	18.00*	046
047	ARTHROPLASTY-REPAIR OF HIP	14.30*	047
048	NEEDLE PUNCTURE OF BURSA	17.10*	048
049	BRONCHOSCOPY	142.60*	049
050	THORACENTESIS	25.70*	050

1979 PREVAILING CHARGE SUMMARY DATA SOUTH DAKOTA MEDICAL SERVICE SOUTH DAKOTA COMBINED LOCALITY DESIGNATION

PROCEDURE DESCRIPTION	SINGLE
051 CATHETERIZATION OF HEART	855.80*
052 INSERTION OF PACEMAKER	713.20*
053 PARTIAL COLECTOMY	315.10*
054 APPENDECTOMY	25.70*
055 SIGMOIDOSCOPY	214.00*
056 HEMORRHOIDECTOMY	513.50*
057 CHOLECYSTECTOMY	299.50*
058 REPAIR HERNIA	42.80*
059 DIAGNOSTIC CYSTOURETHROSCOPY	16.00
060 DILATION OF URETHRA	680.00
061 PROSTATECTOMY	641.90*
062 ELECTROSECTION-PROSTATE (TUR)	499.20*
063 HYSTERECTOMY	19.60*
064 INITIAL COMPLETE EYE EXAM	10.00
065 COMPREHENSIVE EYE EXAM	684.70*
066 EYE EXAM WITH TONOMETRY	16.50
067 EXTRACTION OF LENS	25.70*
068 CHEST X-RAY, SINGLE VIEW	28.00
069 CHEST X-RAY, TWO VIEWS	28.50*
070 X-RAY SPINE	51.40
071 X-RAY HIP	49.90*
072 X-RAY UPPER GI TRACT	16.50
073 X-RAY COLON	50.00
074 RADIATION THERAPY-LOW VOLT	50.00
075 RADIATION THERAPY-SUPER VOLT	15.00
076 RADIATION THERAPY-MEGAVOLT	7.50*
077 CAT SCAN - HEAD	4.00
078 CAT SCAN-HEAD, INTERPRET ONLY	4.00
079 THREE CHEMISTRY TESTS	8.60*
080 TWELVE CHEMISTRY TESTS	7.10*
081 CULTURE-OTHER THAN BLOOD	3.00
082 HEMOCULOGIN	3.50
083 AUTOMATED BLOOD COUNT	5.00
084 WHITE CELL COUNT	9.00
085 COMPLETE BLOOD COUNT (CEC)	7.10*
086 CHOLESTEROL TEST	3.00
087 FLOCCULATION TEST	3.50
088 HEMATOCRIT	5.00
089 PLATELET COUNT (REES-ECKER)	9.00
090 POTASSIUM TEST	7.10*
091 PROTHROMBIN	4.00
092 SEDIMENTATION RATE	7.00
093 BLOOD SUGAR	8.00
094 SUN-UREA, NITROGEN	8.50
095 URIC ACID	3.00
096 FECES-OCCULT BLOOD	9.50
097 PAP TEST	4.20
098 ROUTINE URINALYSIS	16.00
099 CHEMICAL URINALYSIS	
100 PATHOLOGY-THREE SPECIMENS	

TENNESSEE

TENNESSEE



One Locality - Statewide

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION 35 35

001 INITIAL BRIEF OFFICE VISIT		17.10*	001
002 INITIAL LIMITED OFFICE VISIT	25.00	35.00	002
003 INIT INTERMED OFFICE VISIT		35.00	003
004 INIT COMP OFFICE VISIT	35.00	42.80*	004
005 MINIMAL F/U OFFICE VISIT	4.20*	4.20*	005
006 BRIEF F/U OFFICE VISIT	7.20*	10.00*	006
007 LIMITED F/U OFFICE VISIT	10.00	14.30*	007
008 INTERMED F/U OFFICE VISIT	10.70*	17.10*	008
009 EXTENDED F/U OFFICE VISIT	18.60*	18.60*	009
010 COMPLETE F/U OFFICE VISIT	10.00	28.50*	010
011 BRIEF F/U HOME VISIT	14.30*	17.10*	011
012 LIMITED F/U HOME VISIT		20.00	012
013 INTERMEDIATE F/U HOME VISIT	18.00	20.00	013
014 EXTENDED CARE FACILITY VISIT		14.30*	014
015 BRIEF F/U NURSING HOME VISIT	7.20*	21.40*	015
016 INITIAL BRIEF HOSPITAL VISIT	21.40*	40.00	016
017 INIT INTERMED HOSPITAL VISIT		49.90*	017
018 INITIAL COMP HOSPITAL VISIT	35.00	11.40*	018
019 BRIEF F/U HOSPITAL VISIT	8.60*	14.30*	019
020 LIMITED F/U HOSPITAL VISIT	12.00	14.30*	020
021 INTERMED F/U HOSPITAL VISIT		25.00	021
022 EXTENDED F/U HOSPITAL VISIT	12.00	13.70*	022
023 BRIEF EMERGENCY ROOM VISIT		17.00*	023
024 LIMITED EMERGENCY ROOM VISIT		28.40*	024
025 INTERMED EMERGENCY ROOM VISIT	14.30*	21.40*	025
026 LIMITED CONSULTATION	14.30*	42.80*	026
027 EXTENSIVE CONSULTATION		60.00	027
028 COMPREHENSIVE CONSULTATION		30.00*	028
029 PSYCHOTHERAPY-ONE HOUR		35.00	029
030 PSYCHOTHERAPY-HALF HOUR	8.50*	8.50*	030
031 CHIROPRACTIC OFFICE VISIT		17.10*	031
032 INITIAL PHYSIOTHERAPY		10.00*	032
033 F/U PODIATRIC OFFICE VISIT		20.00	033
034 ELECTROCARDIOGRAM (EKG)	20.00	5.00	034
035 EKG-INTERPRET. REPORT ONLY	7.50		035
036 ARTERIAL BLOOD GAS STUDY		57.10*	036
037 ELECTROENCEPHALOGRAM (EEG)			037
038 CHEMOTHERAPY			038
039 COLLECTION OF SPECIMENS		3.00	039
040 DEBRIDEMENT OF NAILS		14.80*	040
041 SKIN BIOPSY		30.00	041
042 CHEMOCAUTERY		15.00	042
043 RADICAL MASTECTOMY		750.00	043
044 OPEN REDUCTION OF FRACTURE		713.20*	044
045 ARTHROCENTESIS-MAJOR JOINT		14.80*	045
046 ARTHROTOMY	13.00	15.00	046
047 ARTHROPLASTY-REPAIR OF HIP		967.80*	047
048 NEEDLE PUNCTURE OF BURSA		20.00	048
049 BRONCHOSCOPY		156.90*	049
050 THORACENTESIS		36.00*	050

1979 PREVAILING CHARGE SUMMARY DATA EQUITABLE LIFE ASSURANCE SOCIETY TENNESSEE

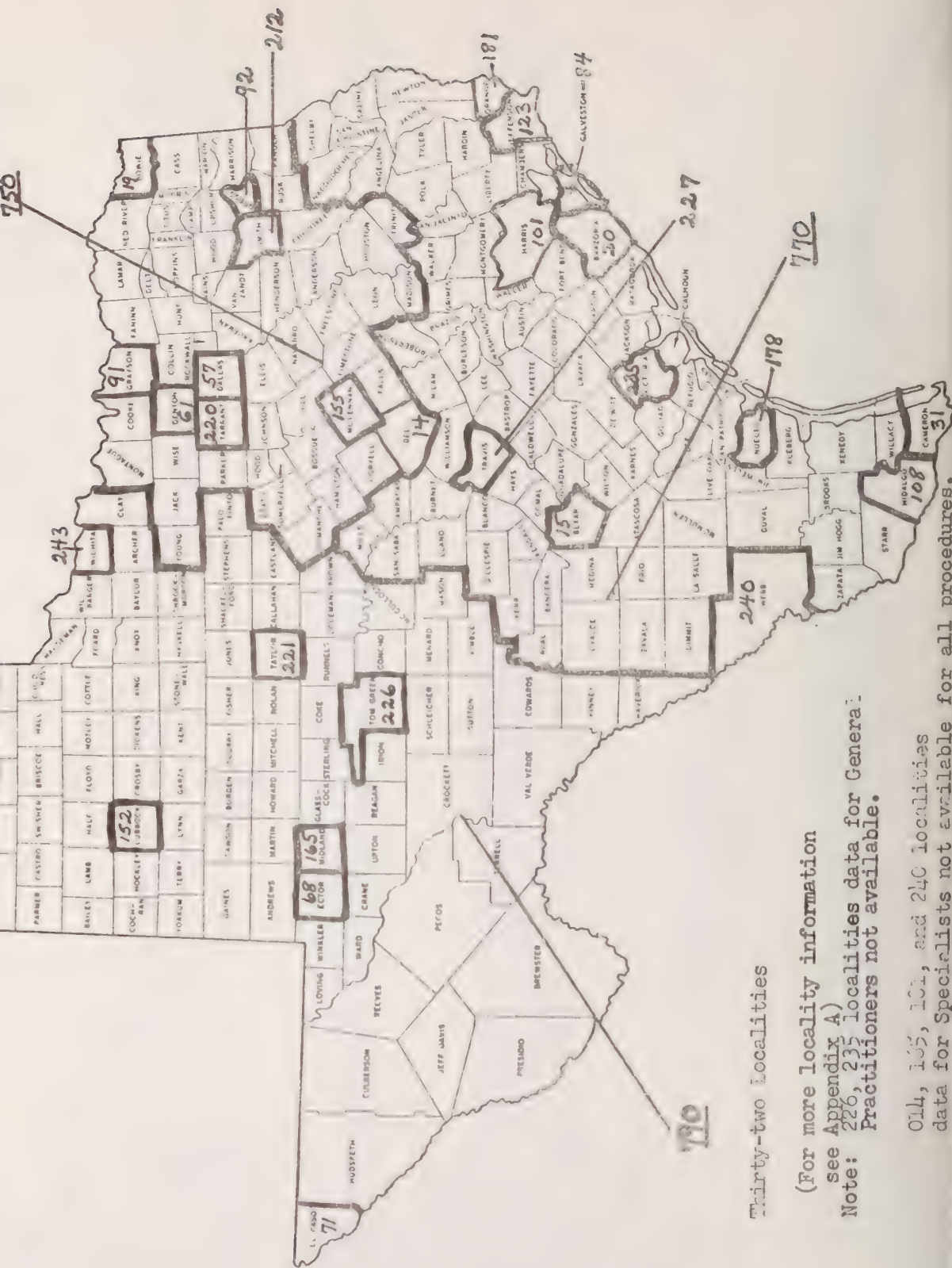
LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	35	35
051 CATHETERIZATION OF HEART		356.60*
052 INSERTION OF PACEMAKER		713.20*
053 PARTIAL COLECTOMY		713.20*
054 APPENDECTOMY		360.00
055 SIGMOIDOSCOPY	21.40*	25.70*
056 HEMORRHOIDECTOMY		285.30*
057 CHOLECYSTECTOMY		517.10*
058 REPAIR HERNIA		320.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY	35.60*	35.60*
060 DILATION OF URETHRA		12.00
061 PROSTATECTOMY		641.90*
062 ELECTROSECTION-PROSTATE (TUR)		627.60*
063 HYSTERECTOMY		570.60*
064 INITIAL COMPLETE EYE EXAM		23.90*
065 COMPREHENSIVE EYE EXAM		23.90*
066 EYE EXAM WITH TONOMETRY		8.90*
067 EXTRACTION OF LENS		570.60*
068 CHEST X-RAY, SINGLE VIEW	570.60*	16.00
069 CHEST X-RAY, TWO VIEWS	15.00	21.40*
070 X-RAY SPINE	21.40*	30.00
071 X-RAY HIP		20.00
072 X-RAY UPPER GI TRACT	49.90*	49.90*
073 X-RAY COLON		42.80*
074 RADIATION THERAPY-LOW VOLT		20.00
075 RADIATION THERAPY-SUPER VOLT		20.00
076 RADIATION THERAPY-MEGAVOLT		20.00
077 CAT SCAN - HEAD		150.00*
078 CAT SCAN-HEAD, INTERPRET ONLY		50.00*
079 THREE CHEMISTRY TESTS		10.50
080 TWELVE CHEMISTRY TESTS		12.60*
081 CULTURE-OTHER THAN BLOOD		10.00
082 HEMOGLOBIN		4.00
083 AUTOMATED BLOOD COUNT		4.00
084 WHITE CELL COUNT		10.00
085 COMPLETE BLOOD COUNT (CBC)		7.00
086 CHOLESTEROL TEST		5.00
087 FLOCCULATION TEST		3.00
088 HEWATOCRIT		6.00
089 PLATELET COUNT (REES-ECKER)		8.00
090 POTASSIUM TEST		6.00
091 PROTHROMBIN		6.00
092 SEDIMENTATION RATE		5.00
093 BLOOD SUGAR		7.00
094 BUN-UREA, NITROGEN		8.00
095 URIC ACID		7.50
096 FECES-OCULT BLOOD		3.50
097 PAP TEST		10.00
098 ROUTINE URINALYSIS		5.00
099 CHEMICAL URINALYSIS		2.00
100 PATHOLOGY-THREE SPECIMENS		20.00

TEXAS

TEXAS

DALLAM	SHERMAN	HANSFORD	UPSHUR	TRINITY
HARTLEY	MOORE	HUNT	ROBERTS	HARRIS
OLICHAM	WHEELER	GRAY	WHEELER	
DEAN	WHEELER	GRAY	WHEELER	
DEAN	WHEELER	GRAY	WHEELER	



Thirty-two Localities

(For more locality information see Appendix A)
 Note: 226, 235 localities data for General Practitioners not available.

014, 165, 181, and 240 localities data for Specialists not available for all procedures.

1979 PREVAILING CHARGE SUMMARY DATA											GROUP MEDICAL AND SURGICAL SERV.			TEXAS						
PROCEDURE DESCRIPTION											LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST						
											014	015	019	020	031	014	015	019	020	031
001	INITIAL BRIEF OFFICE VISIT															16.00*				15.00
002	INITIAL LIMITED OFFICE VISIT																			
003	INIT INTERMED OFFICE VISIT																			
004	INIT COMP OFFICE VISIT	35.00	30.00	28.00	30.00	28.50*										49.90*				49.90*
005	MINIMAL F/U OFFICE VISIT																			
006	BRIEF F/U OFFICE VISIT	7.10*	10.00*	10.00*	10.00*	7.10*										14.30*				10.00*
007	LIMITED F/U OFFICE VISIT	9.00	14.30*	10.00*	10.00*	11.40*										14.30*				11.40*
008	INTERMED F/U OFFICE VISIT	14.30*	18.00	15.00	10.00*	11.40*										20.00				20.00
009	EXTENDED F/U OFFICE VISIT	20.00	17.00*	29.90*	25.00	14.30*										26.00*				30.00
010	COMPLETE F/U OFFICE VISIT	30.00	30.00	30.00	30.00	25.00										42.80*				35.70*
011	BRIEF F/U HOME VISIT	14.30*	17.10	14.30*	15.00	10.00										17.10*	14.30*	15.00		10.00
012	LIMITED F/U HOME VISIT															19.00	17.10*	16.00*		15.00*
013	INTERMEDIATE F/U HOME VISIT																			
014	EXTENDED CARE FACILITY VISIT															67.50				67.50
015	BRIEF F/U NURSING HOME VISIT	7.10*	10.00	7.10*	10.00*	7.10										14.30*				10.00*
016	INITIAL BRIEF HOSPITAL VISIT	35.70*	35.70*	21.40*	28.50*	35.70*										42.80*				30.00*
017	INIT INTERMED HOSPITAL VISIT															49.90*				35.00
018	INITIAL COMP HOSPITAL VISIT	35.70*	50.00	35.00	30.00	35.70*										57.00*				49.90*
019	BRIEF F/U HOSPITAL VISIT	11.50*	15.00*	12.80*	14.30*	9.00*										14.30*				10.70*
020	LIMITED F/U HOSPITAL VISIT	14.30*	20.00	14.30*	15.00	15.00										20.00				14.30*
021	INTERMED F/U HOSPITAL VISIT																			
022	EXTENDED F/U HOSPITAL VISIT															40.00				26.00
023	BRIEF EMERGENCY ROOM VISIT															14.30*				10.00*
024	LIMITED EMERGENCY ROOM VISIT															16.00*				15.00
025	INTERMED EMERGENCY ROOM VISIT															28.50*				35.70*
026	LIMITED CONSULTATION	29.90*	28.50*	31.40*	35.70*	14.30*										35.70*				35.70*
027	EXTENSIVE CONSULTATION															36.00*				35.00
028	COMPREHENSIVE CONSULTATION															70.00				49.90
029	PSYCHOTHERAPY-ONE HOUR															42.80*				
030	PSYCHOTHERAPY-HALF HOUR															28.50*				
031	CHIROPRACTIC OFFICE VISIT	8.00*	9.00*	10.00	10.00	8.60*										9.00				
032	INITIAL PHYSIOTHERAPY																			
033	F/U PODIATRIC OFFICE VISIT																			
034	ELECTROCARDIOGRAM (EKG)	20.00	25.00	20.00	21.40*	21.40*										25.00				23.00
035	EKG-INTERPRET-REPORT ONLY																			
036	ARTERIAL BLOOD GAS STUDY															26.50				26.50
037	ELECTROENCEPHALOGRAM (EEG)																			
038	CHEMOTHERAPY															17.10*				25.00
039	COLLECTION OF SPECIMENS																			
040	DEBRIDEMENT OF NAILS																			
041	SKIN BIOPSY															20.00	15.70*	17.10*		17.10*
042	CHEMOCAUTERY															35.00	26.80*	15.70*		35.00
043	RADICAL MASTECTOMY															25.00	25.00	25.00*		25.00
044	OPEN REDUCTION OF FRACTURE															810.00	529.00*	588.90*		588.90*
045	ARTHROCENTESIS-MAJOR JOINT															570.40*				
046	ARTHROTOMY																			
047	ARTHROPLASTY-REPAIR OF HIP															21.40*				
048	NEEDLE PUNCTURE OF BURSA															1140.60*				
049	BRONCHOSCOPY															21.40*	15.70*	17.10*		17.10*
050	THORACENTESIS	20.00	21.40*	16.00	16.00	21.40*										190.00	114.10*	126.90*		126.90*
																50.00	22.80*	25.70*		50.00

1979 PREVAILING CHARGE SUMMARY DATA

TEXAS

GROUP MEDICAL AND SURGICAL SERV.

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	014	015	019	020	031	014	015	019	020	031
051 CATHETERIZATION OF HEART										
052 INSERTION OF PACEMAKER										
053 PARTIAL COLECTOMY										
054 APPENDECTOMY										
055 SIGMOIDOSCOPY	26.25*	35.00	28.50*	28.50*	35.00		855.60*	604.60*	673.10*	673.50*
056 HEMORRHOIDECTOMY							427.80*	285.20*	400.00*	356.50*
057 CHOLECYSTECTOMY							35.00	23.50*	25.70*	40.00
058 REPAIR HERNIA							250.00*	151.20*	168.30*	168.30*
059 DIAGNOSTIC CYSTOURETHROSCOPY	62.70*	85.60*	75.60*	74.20*	74.20*		641.70*	427.80*	504.80*	499.10*
060 DILATION OF URETHRA							427.80*	285.20*	295.20*	285.20*
061 PROSTATECTOMY							90.00			
062 ELECTROSECTION-PROSTATE (TUR)	627.40*	800.00	752.90*	741.50*	627.40*		14.00			
063 HYSTERECTOMY							713.00*			
064 INITIAL COMPLETE EYE EXAM							684.50*			
065 COMPREHENSIVE EYE EXAM							798.60*			
066 EYE EXAM WITH TONOMETRY							28.50*			
067 EXTRACTION OF LENS							12.00			
068 CHEST X-RAY, SINGLE VIEW	750.00	720.00	750.00	750.00	750.00		713.00			
069 CHEST X-RAY, TWO VIEWS	20.00	15.00	14.30*	18.50	17.00*		21.00			
070 X-RAY SPINE	21.40*	24.20*	14.30*	21.40*	22.00		22.00			
071 X-RAY HIP							30.00			
072 X-RAY UPPER GI TRACT	15.00	10.00	15.00	15.00	15.00		24.00			
073 X-RAY COLON							58.00			
074 RADIATION THERAPY-LOW VOLT	20.00	15.00	17.10*	20.00	17.10*		44.00			
075 RADIATION THERAPY-SUPER VOLT	24.20*	25.00	21.40*	24.20*	20.00*		17.00			
076 RADIATION THERAPY-MEGAVOLT							25.00			
077 CAT SCAN - HEAD										
078 CAT SCAN-HEAD, INTERPRET ONLY							95.00			
079 THREE CHEMISTRY TESTS							60.00			
080 TWELVE CHEMISTRY TESTS										
081 CULTURE-OTHER THAN BLOOD										
082 HEMOGLOBIN										
083 AUTOMATED BLOOD COUNT										
084 WHITE CELL COUNT										
085 COMPLETE BLOOD COUNT (CBC)										
086 CHOLESTEROL TEST										
087 FLOCCULATION TEST										
088 HEMATOCRIT										
089 PLATELET COUNT (REES-ECKER)										
090 POTASSIUM TEST										
091 PROTHROMBIN										
092 SEDIMENTATION RATE										
093 BLOOD SUGAR										
094 BUN-UREA, NITROGEN										
095 URIC ACID										
096 FECES-OCCULT BLOOD										
097 PAP TEST										
098 ROUTINE URINALYSIS										
099 CHEMICAL URINALYSIS										
100 PATHOLOGY-THREE SPECIMENS										

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

1979 PREVAILING CHARGE SUMMARY DATA GROUP MEDICAL AND SURGICAL SERV. TEXAS

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

057 061 068 071 084 057 061 068 071 084

001 INITIAL BRIEF OFFICE VISIT	40.00	40.00	45.00	25.00	35.00	25.00*	25.00*	25.00*	20.00*	001
002 INITIAL LIMITED OFFICE VISIT										002
003 INIT INTERMED OFFICE VISIT										003
004 INIT COMP OFFICE VISIT										004
005 MINIMAL F/U OFFICE VISIT										005
006 BRIEF F/U OFFICE VISIT	11.40*	10.70*	7.10*	8.60*	10.00*	14.30*	14.30*	11.40*	16.00	006
007 LIMITED F/U OFFICE VISIT	14.30*	11.40*	10.00	14.30*	14.30*	15.00*	15.00*	11.40*	14.30	007
008 INTERMED F/U OFFICE VISIT	17.00	10.00*	10.00	15.00	20.00	22.00*	22.00*	18.00	20.00	008
009 EXTENDED F/U OFFICE VISIT	20.00	20.00	17.10*	15.00	20.00	22.00*	22.00*	25.00*	28.50*	009
010 COMPLETE F/U OFFICE VISIT	25.00	28.50*	30.00	25.00	18.50	42.80*	42.80*	35.70*	45.00	010
011 BRIEF F/U HOME VISIT	20.00	14.30*	14.30*	20.00	20.00	20.00	14.30*	20.00	20.00	011
012 LIMITED F/U HOME VISIT						24.20*	20.00	20.00	20.00	012
013 INTERMEDIATE F/U HOME VISIT										013
014 EXTENDED CARE FACILITY VISIT						67.50	67.50	67.50	67.50	014
015 BRIEF F/U NURSING HOME VISIT	11.40*	10.70	17.10*	8.60	10.00*	14.30*	11.40*	11.40*	16.00*	015
016 INITIAL BRIEF HOSPITAL VISIT	35.70*	25.70*	25.00*	30.00	32.80*	49.90*	35.70*	35.70*	40.00*	016
017 INIT INTERMED HOSPITAL VISIT						49.90*	49.90*	49.90*	55.00	017
018 INITIAL COMP HOSPITAL VISIT	42.00	49.90*	35.70*	35.00	35.00	49.90*	49.90*	49.90*	70.00	018
019 BRIEF F/U HOSPITAL VISIT	15.00*	10.90*	8.00*	14.30*	14.30*	15.00*	14.30*	14.30*	17.10*	019
020 LIMITED F/U HOSPITAL VISIT	15.00*	16.60*	10.00*	15.00	21.00*	20.00	14.30*	14.30*	25.00*	020
021 INTERMED F/U HOSPITAL VISIT										021
022 EXTENDED F/U HOSPITAL VISIT						29.00*	25.00	25.00	26.00	022
023 BRIEF EMERGENCY ROOM VISIT						14.30*	11.40*	11.40*	16.00	023
024 LIMITED EMERGENCY ROOM VISIT						25.00*	25.00*	25.00*	20.00*	024
025 INTERMED EMERGENCY ROOM VISIT						35.00	11.40*	11.40*	20.00*	025
026 LIMITED CONSULTATION	35.00	31.40*	40.00	25.00	35.00*	42.80*	40.00	40.00	35.00*	026
027 EXTENSIVE CONSULTATION						49.90*	35.00	35.00	45.00	027
028 COMPREHENSIVE CONSULTATION						71.30*	49.90	49.90	70.00	028
029 PSYCHOTHERAPY-ONE HOUR						45.00			60.00	029
030 PSYCHOTHERAPY-HALF HOUR						20.00	21.40*		21.40*	030
031 CHIROPRACTIC OFFICE VISIT	10.00	10.00	8.60*	10.00	10.00	10.00			10.00	031
032 INITIAL PHYSIOTHERAPY										032
033 F/U PODIATRIC OFFICE VISIT										033
034 ELECTROCARDIOGRAM (ECG)	20.00	21.00	25.00	21.40*	21.40*	22.00	21.40*	21.40*	25.00*	034
035 EKG-INTERPRET, REPORT ONLY										035
036 ARTERIAL BLOOD GAS STUDY						26.50	26.50	26.50	26.50	036
037 ELECTROENCEPHALOGRAM (EEG)										037
038 CHEMOTHERAPY						17.10*	17.00	17.00	20.00	038
039 COLLECTION OF SPECIMENS										039
040 DEBRIDEMENT OF NAILS										040
041 SKIN BIOPSY						20.00	17.10*	20.00	18.50*	041
042 CHEMOCAUTERY						31.00	25.70*	29.90*	25.80*	042
043 RADICAL MASTECTOMY						25.00	25.00	25.00	25.00	043
044 OPEN REDUCTION OF FRACTURE						1000.00	632.80*	800.00	800.00*	044
045 ARTHROCENTESIS-MAJOR JOINT						713.00*	926.90*	926.90*		045
046 ARTHROTOMY										046
047 ARTHROPLASTY-REPAIR OF HIP	20.00	20.00	16.00	21.40*	21.40*	17.00	20.00	20.00		047
048 NEEDLE PUNCTURE OF BURSA						1195.00*	1176.50*	1176.50*		048
049 BRONCHOSCOPY						15.00*	17.10*	20.00	18.50*	049
050 THORACENTESIS						178.25*	142.60*	190.00	139.70*	050
						50.00	50.00	50.00	35.70*	

1979 PREVAILING CHARGE SUMMARY DATA

TEXAS

GROUP MEDICAL AND SURGICAL SERV.

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	057	061	068	071	084	057	061	068	071	084
051 CATHETERIZATION OF HEART						359.50*				
052 INSERTION - PACEMAKER						1140.00*				
053 PARTIAL COLECTOMY						1000.00				
054 APPENDECTOMY						399.50*	684.50*	661.70*	798.60*	741.50*
055 SIGMOIDECTOMY						35.70*	20.00	25.70*	45.00	49.90*
056 HEMORRHOIDECTOMY	40.00	31.70*	35.00	25.00	49.90*	246.50*	171.10*	165.40*	199.60*	185.40*
057 COLECYSTECTOMY						713.00*	499.10*	570.40*	585.00	606.10*
058 REPAIR HERNIA						392.20*	356.50*	356.50*	356.50*	415.00
059 DIAGNOSTIC CYSTOURETHROSCOPY	132.00	81.30*	68.40*	74.20*	74.20*	142.50*				
060 DILATION OF URETHRA						15.00				
061 PROSTATECTOMY						784.30*				
062 ELECTROSECTION-PROSTATE (TUR)	200.00	800.00	900.00	730.10*	730.10*	713.00*				
063 HYSTERECTOMY						728.70*			611.30*	750.00*
064 INITIAL COMPLETE EYE EXAM						28.50*			25.00	
065 COMPREHENSIVE EYE EXAM									10.00	
066 EYE EXAM WITH TONOMETRY						15.00			570.40*	
067 EXTRACTION OF LENS	800.00	750.00	750.00	675.00	750.00	663.10*				
068 CHEST X-RAY, SINGLE VIEW	20.00	20.00	18.00	16.50	20.00	12.00				
069 CHEST X-RAY, TWO VIEWS	23.00	21.00	25.00	22.80*	25.70	25.00				
070 X-RAY SPINE						28.00				
071 X-RAY HIP						17.50				
072 X-RAY UPPER GI TRACT	15.00	15.00	15.00	15.00	15.00	71.30*				
073 X-RAY COLON						53.00				
074 RADIATION THERAPY-LOW VOLT	20.00	20.00	20.00	20.00	20.00	15.00				
075 RADIATION THERAPY-SUPER VOLT	20.00	25.50	25.50	24.20*	25.50	20.00				
076 RADIATION THERAPY-MEGAVOLT										
077 CAT SCAN - HEAD						95.00				
078 CAT SCAN-HEAD, INTERPRET ONLY						60.00				
079 THREE CHEMISTRY TESTS										
080 TWELVE CHEMISTRY TESTS										
081 CULTURE-OTHER THAN BLOOD										
082 HEMOGLOBIN										
083 AUTOMATED BLOOD COUNT										
084 WHITE CELL COUNT										
085 COMPLETE BLOOD COUNT (CBC)										
086 CHOLESTEROL TEST										
087 FLOCCULATION TEST										
088 HEMATOOCRIT										
089 PLATELET COUNT (REES-ECKER)										
090 POTASSIUM TEST										
091 PROTHROMBIN										
092 SEDIMENTATION RATE										
093 BLOOD SUGAR										
094 BUN-CREANINITROGEN										
095 URIC ACID										
096 FECES-OCULT BLOOD										
097 PAP TEST										
098 ROUTINE URINALYSIS										
099 CHEMICAL URINALYSIS										
100 PATHOLOGY-THREE SPECIMENS										

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	091	092	101	108	123	091	092	101	108	123
001 INITIAL BRIEF OFFICE VISIT										
002 INITIAL LIMITED OFFICE VISIT										
003 INIT INTERMED OFFICE VISIT										
004 INIT COMP OFFICE VISIT	34.00	28.50*	35.00	28.00	30.00					
005 MINIMAL F/U OFFICE VISIT										
006 BRIEF F/U OFFICE VISIT	7.10*	8.60*	10.00*	7.10*	10.00*					
007 LIMITED F/U OFFICE VISIT	10.00*	10.00	14.00	10.00*	11.40*					
008 INTERMED F/U OFFICE VISIT	11.40*	16.00	15.00	8.60*	14.00*					
009 EXTENDED F/U OFFICE VISIT	20.00	20.00	15.00	12.00	21.40*					
010 COMPLETE F/U OFFICE VISIT	30.00	30.00	35.00	30.00	50.00*					
011 BRIEF F/U HOME VISIT	12.20*	14.30*	20.00	14.30*	17.10*					
012 LIMITED F/U HOME VISIT						12.60*	14.30*			
013 INTERMEDIATE F/U HOME VISIT						18.00*	20.00			
014 EXTENDED CARE FACILITY VISIT										
015 BRIEF F/U NURSING HOME VISIT	7.10*	8.60*	10.00*	7.10*	10.00*					
016 INITIAL BRIEF HOSPITAL VISIT	21.40*	25.00	35.70*	28.50*	35.00					
017 INIT INTERMED HOSPITAL VISIT										
018 INITIAL COMP HOSPITAL VISIT	25.00	35.70*	42.80*	35.70*	35.00					
019 BRIEF F/U HOSPITAL VISIT	11.40*	8.60*	14.30*	10.00	14.30*					
020 LIMITED F/U HOSPITAL VISIT	14.30*	21.40*	17.10*	15.00*	18.60*					
021 INTERMED F/U HOSPITAL VISIT										
022 EXTENDED F/U HOSPITAL VISIT										
023 BRIEF EMERGENCY ROOM VISIT	7.10*	8.60*	10.00*	7.10*	10.00*					
024 LIMITED EMERGENCY ROOM VISIT	21.40*	25.00	35.70*	28.50*	35.00					
025 INTERMED EMERGENCY ROOM VISIT										
026 LIMITED CONSULTATION	25.00*	29.90*	35.00*	21.40*	23.60*					
027 EXTENSIVE CONSULTATION										
028 COMPREHENSIVE CONSULTATION										
029 PSYCHOTHERAPY-ONE HOUR										
030 PSYCHOTHERAPY-HALF HOUR										
031 CHIROPRACTIC OFFICE VISIT	10.00	10.00	11.40*	10.00	11.00					
032 INITIAL PHYSIOTHERAPY										
033 F/U PODIATRIC OFFICE VISIT										
034 ELECTROCARDIOGRAM (EKG)	21.40*	21.40*	25.00	21.40*	21.40*					
035 EKG-INTERPRET-REPORT ONLY										
036 ARTERIAL BLOOD GAS STUDY										
037 ELECTROENCEPHALOGRAM (EEG)										
038 CHEMOTHERAPY										
039 COLLECTION OF SPECIMENS										
040 DEBRIDEMENT OF NAILS										
041 SKIN BIOPSY										
042 CHEMOCAUTERY										
043 RADICAL WASTECTOMY										
044 OPEN REDUCTION OF FRACTURE										
045 ARTHROCTOMY-MAJOR JOINT										
046 ARTHROTOMY										
047 ARTHROPLASTY-REPAIR OF HIP										
048 NEEDLE PUNCTURE OF BURSA										
049 BRONCHOSCOPY										
050 THORACENTESIS										

179 PREVAILING CHARGE SUMMARY DATA GROUP MEDICAL AND SURGICAL SERV.

TEXAS

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE				LOCALITY DESIGNATION FOR SPECIALISTS				
	091	092	101	108	123	091	092	101	108
051 CATHETERIZATION OF HEART								392.20*	
052 INSERTION OF PACEMAKER								1026.70*	
053 PARTIAL COLECTOMY						604.60*	604.60*	878.40*	638.80*
054 APPENDECTOMY						285.20*	320.90*	427.80*	326.00
055 SIGMOIDOSCOPY						24.20*	22.80*	42.60*	25.00*
056 HEMORRHOIDECTOMY					35.70*	151.20*	151.20*	219.60*	175.00*
057 CHOLECYSTECTOMY						604.60*	499.10*	713.00*	500.00
058 REPAIR HERNIA						285.00*	285.20*	427.80*	300.00
059 DIAGNOSTIC CYSTOURETHROSCOPY								142.60*	
060 DILATION OF URETHRA					78.40*			20.00	
061 PROSTATECTOMY								713.00*	
062 ELECTROSECTION-PROSTATE (TUR)					775.70*			713.00*	
063 HYSTERECTOMY								829.00*	
064 INITIAL COMPLETE EYE EXAM								35.00	
065 COMPREHENSIVE EYE EXAM									
066 EYE EXAM WITH TONOMETRY									
067 EXTRACTION OF LENS								14.30*	
068 CHEST X-RAY, SINGLE VIEW					484.80*			713.00*	
069 CHEST X-RAY, TWO VIEWS					21.40*			12.75*	
070 X-RAY SPINE					25.00			23.00	
071 X-RAY HIP								39.90*	
072 X-RAY UPPER GI TRACT								24.00*	
073 X-RAY COLON					15.00			65.00	
074 RADIATION THERAPY-LOW VOLT								47.00	
075 RADIATION THERAPY-SUPER VOLT					20.00			16.00*	
076 RADIATION THERAPY-MEGAVOLT					25.50			19.00*	
077 CAT SCAN - HEAD									
078 CAT SCAN-HEAD, INTERPRET ONLY								95.00	
079 THREE CHEMISTRY TESTS								60.00	
080 TWELVE CHEMISTRY TESTS									
081 CULTURE-OTHER THAN BLOOD									
082 HEMOGLOBIN						13.00	13.00	13.00	13.00
083 AUTOMATED BLOOD COUNT						3.25	3.25	3.25	3.25
084 WHITE CELL COUNT						8.00	8.00	8.00	8.00
085 COMPLETE BLOOD COUNT (CBC)						3.25	3.25	3.25	3.25
086 CHOLESTEROL TEST						8.00	8.00	8.00	8.00
087 FLOCCULATION TEST						8.00	8.00	8.00	8.00
088 HEMATOCRIT						7.00	7.00	7.00	7.00
089 PLATELET COUNT (REES-ECKER)						3.00	3.00	3.00	3.00
090 POTASSIUM TEST						6.00	6.00	6.00	6.00
091 PROTHROMBIN						7.30	7.30	7.30	7.30
092 SEDIMENTATION RATE						6.50	6.50	5.50	6.50
093 BLOOD SUGAR						5.60	5.60	5.60	5.60
094 BUN-UREA, NITROGEN						7.00	7.00	7.00	7.00
095 URIC ACID						8.00	8.00	8.00	8.00
096 FECES-OCULT BLOOD						8.00	8.00	8.00	8.00
097 PAP TEST						4.00	4.00	4.00	4.00
098 ROUTINE URINALYSIS						7.90	7.90	7.90	7.90
099 CHEMICAL URINALYSIS						5.00	5.00	5.00	5.00
100 PATHOLOGY-THREE SPECIMENS						35.00	35.00	35.00	35.00

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

1979 PREVAILING CHARGE SUMMARY DATA

GROUP MEDICAL AND SURGICAL SERV.

TEXAS

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	152	155	165	178	181	152	155	165	178	181
001 INITIAL BRIEF OFFICE VISIT										001
002 INITIAL LIMITED OFFICE VISIT										002
003 INIT INTERMED OFFICE VISIT										003
004 INIT COMP OFFICE VISIT	35.00	35.00	35.70*	28.50*	45.00	21.00*	21.40*		25.00*	004
005 MINIMAL F/U OFFICE VISIT										005
006 BRIEF F/U OFFICE VISIT	10.00*	7.10*	10.00*	8.60*	8.60*	14.30*	8.60*		14.30*	006
007 LIMITED F/U OFFICE VISIT	10.70*	12.00*	9.00*	14.30*	10.00	14.30*	14.00		14.30*	007
008 INTERMED F/U OFFICE VISIT	10.00	14.30*	10.00*	17.00*	14.30*	20.00	15.00*		17.00*	008
009 EXTENDED F/U OFFICE VISIT	12.00	20.00	20.00	21.40*	20.00	16.00	25.00		25.00*	009
010 COMPLETE F/U OFFICE VISIT	25.00*	20.00	30.00	28.50*	30.00	42.80*	25.00		35.70*	010
011 BRIEF F/U HOME VISIT	14.30*	10.00*	15.00	21.40*	15.00	14.30*	10.00*	15.00*	21.40*	011
012 LIMITED F/U HOME VISIT						15.00	14.30*		20.00	012
013 INTERMEDIATE F/U HOME VISIT										013
014 EXTENDED CARE FACILITY VISIT						67.50	61.30*		67.50	014
015 BRIEF F/U NURSING HOME VISIT	10.00*	7.10*	10.00*	8.60*	8.60*	14.30*	8.60*		14.30*	015
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	21.40*	35.00	28.50*	35.00	49.90*	21.40*		50.00	016
017 INIT INTERMED HOSPITAL VISIT						42.80*	35.70*		49.90*	017
018 INITIAL COMP HOSPITAL VISIT	35.00	25.00	35.70*	45.00	37.00	49.90*	50.00		57.00*	018
019 BRIEF F/U HOSPITAL VISIT	8.60*	10.00	8.60*	14.30*	10.00*	14.30*	9.00		15.00*	019
020 LIMITED F/U HOSPITAL VISIT	14.30*	14.30*	16.00	14.60*	15.00	15.00	14.30*		21.40	020
021 INTERMED F/U HOSPITAL VISIT										021
022 EXTENDED F/U HOSPITAL VISIT						26.00	26.00		25.00	022
023 BRIEF EMERGENCY ROOM VISIT						14.30*	8.60*		14.30*	023
024 LIMITED EMERGENCY ROOM VISIT						21.00*	21.40*		25.00*	024
025 INTERMED EMERGENCY ROOM VISIT						35.70*	21.40*		35.70*	025
026 LIMITED CONSULTATION	35.70*	21.40*	21.40*	35.00	15.00*	42.80*	35.00		42.80*	026
027 EXTENSIVE CONSULTATION						42.80*	49.90*		40.00	027
028 COMPREHENSIVE CONSULTATION						49.90*	50.00		57.00*	028
029 PSYCHOTHERAPY-ONE HOUR										029
030 PSYCHOTHERAPY-HALF HOUR										030
031 CHIROPRACTIC OFFICE VISIT	10.00*	10.00	10.00	10.00	10.00	11.40*	10.00		10.00	031
032 INITIAL PHYSIOTHERAPY										032
033 F/U PODIATRIC OFFICE VISIT										033
034 ELECTROCARDIOGRAM (EKG)	22.80*	17.80*	21.40*	22.50	25.00	22.80*	22.00		22.00	034
035 EKG-INTERPRET-REPORT ONLY										035
036 ARTERIAL BLOOD GAS STUDY						26.50	26.50		26.50	036
037 ELECTROENCEPHALOGRAM (EEG)										037
038 CHEMOTHERAPY						25.00	20.00		20.00	038
039 COLLECTION OF SPECIMENS										039
040 DEBRIDEMENT OF NAILS										040
041 SKIN BIOPSY						17.10*	18.50*		18.50*	041
042 CHEMOCAUTERY						28.50*	28.50		35.00	042
043 RADICAL MASTECTOMY						25.00	25.00		25.00	043
044 OPEN REDUCTION OF FRACTURE						641.70*	677.40*		850.00	044
045 ARTHROCENTESIS-MAJOR JOINT									641.70*	045
046 ARTHROTOMY										046
047 ARTHROPLASTY-REPAIR OF HIP	10.00	16.00	10.00	20.00	16.00				23.00	047
048 NEEDLE PUNCTURE OF BURSA						17.10*	20.00*		1620.00	048
049 BRONCHOSCOPY						126.90*	178.25*		18.50*	049
050 BRONCHITIS						27.90*	35.70*		136.90*	050

PREVAILING CHARGE SUMMARY DATA

TEXAS

GROUP MEDICAL AND SURGICAL SERV.

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	152	155	165	178	181	152	155	165	178	181
051 CATHETERIZATION OF HEART										051
052 INSERTION OF PACEMAKER										052
053 PARTIAL COLECTOMY						673.10*	741.50*		730.10*	053
054 APPENDICECTOMY						356.50*	300.00*		356.50*	054
055 Sigmoidoscopy	25.70*	25.70	25.70*	28.80*	35.00	32.50*	35.70		35.00	055
056 HEMORRHOIDECTOMY						168.30*	185.40*		182.50*	056
057 CHOLECYSTECTOMY						463.50*	450.00		499.10*	057
058 REPAIR HERNIA						320.90*	285.00*		356.50*	058
059 DIAGNOSTIC CYSTOURETHROSCOPY	67.00*	64.80	68.40*	90.00	72.70					059
060 DILATION OF URETHRA										060
061 PROSTATECTOMY										061
062 ELECTROSECTION-PROSTATE (TUR)	551.70*	684.50	684.50	741.50*	718.70*					062
063 HYSTERECTOMY						638.80*			650.00	063
064 INITIAL COMPLETE EYE EXAM						25.00			28.50*	064
065 COMPREHENSIVE EYE EXAM										065
066 EYE EXAM WITH TONOMETRY						10.00			10.00	066
067 EXTRACTION OF LENS	550.00	750.00	750.00	650.00	750.00	570.40*			650.00	067
068 CHEST X-RAY, SINGLE VIEW	15.00	13.50	17.10*	20.00	20.00					068
069 CHEST X-RAY, TWO VIEWS	21.40*	20.00	22.50	25.00*	20.00					069
070 X-RAY SPINE										070
071 X-RAY HIP										071
072 X-RAY UPPER GI TRACT	15.00	15.00	15.00	15.00	15.00					072
073 X-RAY COLON										073
074 RADIATION THERAPY-LOW VOLT	20.00	18.50*	20.00	17.00*	20.00					074
075 RADIATION THERAPY-SUPER VOLT	25.50	22.80*	25.50	20.00*	25.50					075
076 RADIATION THERAPY-MEGAVOLT										076
077 CAT SCAN - HEAD										077
078 CAT SCAN-HEAD, INTERPRET ONLY										078
079 THREE CHEMISTRY TESTS										079
080 TWELVE CHEMISTRY TESTS										080
081 CULTURE-OTHER THAN BLOOD										081
082 HEMOGLOBIN						13.00	13.00	13.00	13.00	082
083 AUTOMATED BLOOD COUNT						3.25	3.25	3.25	3.25	083
084 WHITE CELL COUNT						8.00	8.00	8.00	8.00	084
085 COMPLETE BLOOD COUNT (CBC)						3.25	3.25	3.25	3.25	085
086 CHOLESTEROL TEST						8.00	8.00	8.00	8.00	086
087 FLOCCULATION TEST						8.00	8.00	8.00	8.00	087
088 HEVATOCRIT						7.00	7.00	7.00	7.00	088
089 PLATELET COUNT (REES-ECKER)						3.00	3.00	3.00	3.00	089
090 POTASSIUM TEST						6.00	6.00	6.00	6.00	090
091 PROTHROMBIN						7.30	7.30	7.30	7.30	091
092 SEDIMENTATION RATE						6.50	6.50	6.50	6.50	092
093 BLOOD SUGAR						5.60	5.60	5.60	5.60	093
094 BUN-UREA-NITROGEN						7.00	7.00	7.00	7.00	094
095 URIC ACID						8.00	8.00	8.00	8.00	095
096 FECES-OCULT BLOOD						8.00	8.00	8.00	8.00	096
097 PAP TEST						4.00	4.00	4.00	4.00	097
098 ROUTINE URINALYSIS						7.90	7.90	7.90	7.90	098
099 CHEMICAL URINALYSIS						5.00	5.00	5.00	5.00	099
100 PATHOLOGY-THREE SPECIMENS						5.00	5.00	5.00	5.00	100
						35.00	35.00	35.00	35.00	

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

1979 PREVAILING CHARGE SUMMARY DATA GROUP MEDICAL AND SURGICAL SERV.

TEXAS

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST				
	188	212	220	221	226	188	212	220	221	226
001 INITIAL BRIEF OFFICE VISIT										001
002 INITIAL LIMITED OFFICE VISIT										002
003 INIT INTERMED OFFICE VISIT										003
004 INIT COMP OFFICE VISIT	36.00*	35.00	30.00	25.00		15.00	25.00*	18.00*	20.00	10.00
005 MINIMAL F/U OFFICE VISIT										004
006 BRIEF F/U OFFICE VISIT	8.60*	10.00*	8.60*	7.10*		49.90*	49.90*	42.80*	35.70*	49.90*
007 LIMITED F/U OFFICE VISIT	10.00	10.00	12.00	10.00		14.30*	14.30*	14.30*	10.00*	11.40*
008 INTERMED F/U OFFICE VISIT	10.00	12.00	14.30*	20.00		10.00*	14.30*	15.00*	14.30*	15.00*
009 EXTENDED F/U OFFICE VISIT	15.00	25.00	15.00	20.00		20.00	18.00*	15.00	20.00	15.00*
010 COMPLETE F/U OFFICE VISIT	30.00	35.00	21.40*	30.00		25.00	35.00	16.00	25.00	35.00
011 BRIEF F/U HOME VISIT	15.00	15.00	17.10*	14.30*		40.00	50.00	28.50*	28.50*	28.50*
012 LIMITED F/U HOME VISIT						15.00	15.00	17.10*	14.30*	
013 INTERMEDIATE F/U HOME VISIT						14.30*	20.00	21.40*	20.00	
014 EXTENDED CARE FACILITY VISIT										013
015 BRIEF F/U NURSING HOME VISIT	8.60*	10.00*	8.60*	7.10*		67.50	67.50	67.50	67.50	67.00*
016 INITIAL BRIEF HOSPITAL VISIT	21.40*	35.70*	27.10*	22.80*		10.00*	10.70*	14.30*	10.00*	11.40*
017 INIT INTERMED HOSPITAL VISIT						35.00	35.70*	35.70*	35.70*	26.00*
018 INITIAL COMP HOSPITAL VISIT	48.00	35.00	35.70*	35.00		35.70	40.00	49.90*	35.70*	35.00*
019 BRIEF F/U HOSPITAL VISIT	11.40*	14.30*	14.30*	11.40*		49.90*	49.90*	57.00*	35.70*	64.20*
020 LIMITED F/U HOSPITAL VISIT	12.00	15.00*	14.30*	16.00		10.00	14.30*	14.30*	14.00*	10.00*
021 INTERMED F/U HOSPITAL VISIT						14.30*	20.00	21.40*	20.00*	14.30*
022 EXTENDED F/U HOSPITAL VISIT										020
023 BRIEF EMERGENCY ROOM VISIT						14.30*	28.50*	25.00	26.00	26.00
024 LIMITED EMERGENCY ROOM VISIT						14.30*	14.30*	14.30*	10.00*	11.40*
025 INTERMED EMERGENCY ROOM VISIT						15.00	25.00*	18.00*	20.00	10.00
026 LIMITED CONSULTATION	21.00	35.00*	35.00*	34.20*		35.70*	42.80*	30.00	28.50*	35.70*
027 EXTENSIVE CONSULTATION						40.00	35.70*	35.70*	35.70*	42.80*
028 COMPREHENSIVE CONSULTATION						49.90*	49.90*	49.90*	35.70*	49.90*
029 PSYCHOTHERAPY-ONE HOUR						49.90*	75.00		44.00	60.00
030 PSYCHOTHERAPY-HALF HOUR										028
031 CHIROPRACTIC OFFICE VISIT	10.00	10.00	10.00	8.60*		10.00				029
032 INITIAL PHYSIOTHERAPY										030
033 F/U PODIATRIC OFFICE VISIT										031
034 ELECTROCARDIOGRAM (EKG)										032
035 EKG-INTERPRET-REPORT ONLY	20.00	20.00	21.40*	20.00		20.00	20.00	20.00	20.00	22.00
036 ARTERIAL BLOOD GAS STUDY										033
037 ELECTROENCEPHALOGRAM (EEG)										034
038 CHEMOTHERAPY										035
039 COLLECTION OF SPECIMENS										036
040 DEBRIDEMENT OF NAILS										037
041 SKIN BIOPSY										038
042 CHEMOCAUTERY										039
043 RADICAL MASTECTOMY										040
044 OPEN REDUCTION OF FRACTURE										041
045 ARTHROCENTESIS-MAJOR JOINT										042
046 ARTHROTOMY	17.00	15.00	15.00	15.00		800.00	713.00*	650.00	713.00*	
047 ARTHROPLASTY-REPAIR OF HIP										043
048 NEEDLE PUNCTURE OF BURSA										044
049 BRONCHOSCOPY										045
050 THORACENTESIS										046

1979 PREVAILING CHARGE SUMMARY DATA

TEXAS

GROUP MEDICAL AND SURGICAL SERV.

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	188	212	220	221	226	188	212	220	221	226
051 CATHETERIZATION OF HEART						700.00*	695.90*	775.70*	673.10*	
052 INSERTION OF PACEMAKER						350.00	300.00	356.50*	400.00	
053 PARTIAL COLECTOMY						30.00	30.00	35.00	25.00	
054 APPENDECTOMY						162.60*	174.00	193.90*	168.30*	
055 SIGMOIDOSCOPY						499.10*	499.10*	570.40*	534.75*	
056 HEMORRHOIDECTOMY						320.90*	320.90*	356.50*	350.00*	
057 CHOLECYSTECTOMY								32.00		
058 REPAIR HERNIA								14.30*		
059 DIAGNOSTIC CYSTOURETHROSCOPY						61.30*	61.30*	713.00*		
060 DILATION OF URETHRA								713.00*		
061 PROSTATECTOMY								708.70*		
062 ELECTROSECTION-PROSTATE (TUR)						504.60*	604.60*	28.50*		
063 HYSTERECTOMY								14.30*		
064 INITIAL COMPLETE EYE EXAM								675.00		
065 COMPREHENSIVE EYE EXAM								17.80*		
066 EYE EXAM WITH TONOMETRY								22.00		
067 EXTRACTION OF LENS						750.00	750.00	675.00	750.00	
068 CHEST X-RAY, SINGLE VIEW						20.00	21.40*	17.80*	16.00	
069 CHEST X-RAY, TWO VIEWS						21.40	20.00	22.00	20.00	
070 X-RAY SPINE								45.00		
071 X-RAY HIP								24.00		
072 X-RAY UPPER GI TRACT						15.00	15.00	57.03*		
073 X-RAY COLON								52.00		
074 RADIATION THERAPY-LOW VOLT						20.00	14.00*	13.90*		
075 RADIATION THERAPY-SUPER VOLT						25.50	16.00*	14.30*		
076 RADIATION THERAPY-NEGAVOLT								95.00		
077 CAT SCAN - HEAD								60.00		
078 CAT SCAN-HEAD, INTERPRET ONLY										
079 THREE CHEMISTRY TESTS										
080 TWELVE CHEMISTRY TESTS										
081 CULTURE-OTHER THAN BLOOD										
082 HEMOGLOBIN						13.00	13.00	13.00	13.00	
083 AUTOMATED BLOOD COUNT						3.25	3.25	3.25	3.25	
084 WHITE CELL COUNT						8.00	8.00	8.00	8.00	
085 COMPLETE BLOOD COUNT (CBC)						3.25	3.25	3.25	3.25	
086 CHOLESTEROL TEST						8.00	8.00	8.00	8.00	
087 FLOCCULATION TEST						8.00	8.00	8.00	8.00	
088 HEMATOCRIT						7.00	7.00	7.00	7.00	
089 PLATELET COUNT (REES-ECKER)						3.00	3.00	3.00	3.00	
090 POTASSIUM TEST						6.00	6.00	6.00	6.00	
091 PROTHROMBIN						7.30	7.30	7.30	7.30	
092 SEDIMENTATION RATE						6.50	6.50	6.50	6.50	
093 BLOOD SUGAR						5.60	5.60	5.60	5.60	
094 BUN-UREA-NITROGEN						7.00	7.00	7.00	7.00	
095 URIC ACID						8.00	8.00	8.00	8.00	
096 FECES-OCCULT BLOOD						4.00	4.00	4.00	4.00	
097 PAP TEST						7.90	7.90	7.90	7.90	
098 ROUTINE URINALYSIS						5.00	5.00	5.00	5.00	
099 CHEMICAL URINALYSIS						5.00	5.00	5.00	5.00	
100 PATHOLOGY-THREE SPECIMENS						35.00	35.00	35.00	35.00	

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

1979 PREVAILING CHARGE SUMMARY DATA GROUP MEDICAL AND SURGICAL SERV.

TEXAS

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALIST					
	227	235	240	243	750	227	235	240	243	750	
001 INITIAL BRIEF OFFICE VISIT						25.00			11.40*	14.30*	001
002 INITIAL LIMITED OFFICE VISIT											002
003 INIT INTERMED OFFICE VISIT											003
004 INIT COMP OFFICE VISIT	35.00		28.00	30.00		55.00			35.70*	35.70*	004
005 MINIMAL F/U OFFICE VISIT											005
006 BRIEF F/U OFFICE VISIT	10.00*		10.00	8.60*		16.00			11.40*	10.00*	006
007 LIMITED F/U OFFICE VISIT	14.30*		10.00*	11.00		18.00			14.30*	14.30*	007
008 INTERMED F/U OFFICE VISIT	14.30*		15.00	17.10*		28.00			22.80*	15.00	008
009 EXTENDED F/U OFFICE VISIT	21.40*		20.00	17.10*		45.00			27.50*	16.00	009
010 COMPLETE F/U OFFICE VISIT	20.00*		30.00	30.00		50.00			45.00	35.00	010
011 BRIEF F/U HOME VISIT	17.10*		15.00	14.30*		17.10*		15.00	14.30*	14.30*	011
012 LIMITED F/U HOME VISIT						17.10*			17.10	15.70*	012
013 INTERMEDIATE F/U HOME VISIT											013
014 EXTENDED CARE FACILITY VISIT						67.50			67.50	67.50	014
015 BRIEF F/U NURSING HOME VISIT	10.00		10.00*	8.60*		13.80*			11.40*	10.00*	015
016 INITIAL BRIEF HOSPITAL VISIT	35.00		28.50*	21.40*		35.70*			28.50*	28.50*	016
017 INIT INTERMED HOSPITAL VISIT						49.90*			35.70*	35.70*	017
018 INITIAL COMP HOSPITAL VISIT	49.90*		32.00	30.00		57.00*			49.90*	42.80*	018
019 BRIEF F/U HOSPITAL VISIT	12.50		14.00	11.40*		14.30*			14.30*	11.40*	019
020 LIMITED F/U HOSPITAL VISIT	20.00*		14.30*	12.00		20.00*			20.00*	15.00	020
021 INTERMED F/U HOSPITAL VISIT											021
022 EXTENDED F/U HOSPITAL VISIT						20.00*			26.00	20.00	022
023 BRIEF EMERGENCY ROOM VISIT						13.80*			11.40*	10.00*	023
024 LIMITED EMERGENCY ROOM VISIT						25.00			11.40*	14.30*	024
025 INTERMED EMERGENCY ROOM VISIT						40.00			27.00*	20.00	025
026 LIMITED CONSULTATION	29.90*		29.90*	29.90*					42.80*	35.70*	026
027 EXTENSIVE CONSULTATION						40.00			35.70*	35.70*	027
028 COMPREHENSIVE CONSULTATION						42.80*			49.90*	50.00	028
029 PSYCHOTHERAPY-ONE HOUR						70.00				28.50*	029
030 PSYCHOTHERAPY-HALF HOUR						28.50*				25.00	030
031 CHIROPRACTIC OFFICE VISIT	10.00		10.00	10.00		21.40*					031
032 INITIAL PHYSIOTHERAPY						10.00					032
033 F/U PODIATRIC OFFICE VISIT									20.00	20.00	033
034 ELECTROCARDIOGRAM (EKG)	20.00		25.00	22.00		20.00					034
035 EKG-INTERPRET. REPORT ONLY											035
036 ARTERIAL BLOOD GAS STUDY						26.50			26.50	26.50	036
037 ELECTROENCEPHALOGRAM (EEG)						14.30*			20.00	25.00	037
038 CHEMOTHERAPY											038
039 COLLECTION OF SPECIMENS											039
040 DEBRIDEMENT OF NAILS						20.00			17.10*	19.70*	040
041 SKIN BIOPSY						23.00*			21.40*	25.00*	041
042 CHEMOCAUTERY						25.00			25.00	22.00	042
043 RADICAL MASTECTOMY						700.00			598.90*	700.00	043
044 OPEN REDUCTION OF FRACTURE						835.00				570.40*	044
045 ARTHROCENTESIS-MAJOR JOINT											045
046 ARTHROTOMY	15.00		16.00	16.00		18.00				15.00	046
047 ARTHROPLASTY-REPAIR OF HIP										1140.80*	047
048 NEEDLE PUNCTURE OF BURSA						20.00			17.10*	17.10*	048
049 BRONCHOSCOPY						145.50*			125.00*	190.00	049
050 THORACENTESIS						29.00*			50.00	35.70*	050

19 PREVAILING CHARGE SUMMARY DATA

TEXAS

GROUP MEDICAL AND SURGICAL SERV.

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE				LOCALITY DESIGNATION FOR SPECIALISTS					
	227	235	240	243	750	227	235	240	243	750
051 CATHETERIZATION OF HEART										449.20*
052 INSERTION OF PACEMAKER										998.20*
053 PARTIAL COLECTOMY									650.00	684.50*
054 APPENDECTOMY									285.00	342.00*
055 SIGMOIDOSCOPY									26.25*	35.00*
056 HEMORRHOIDECTOMY									171.10*	171.10*
057 CHOLECYSTECTOMY									499.10*	550.00
058 REPAIR HERNIA									285.20*	320.90*
059 DIAGNOSTIC CYSTOURETHROSCOPY										114.10*
060 DILATION OF URETHRA										13.50*
061 PROSTATECTOMY										684.50*
062 ELECTROSECTION-PROSTATE (TUR)										677.40*
063 HYSTERECTOMY										628.90*
064 INITIAL COMPLETE EYE EXAM										28.50*
065 COMPREHENSIVE EYE EXAM										10.00
066 EYE EXAM WITH TONOMETRY										606.10*
067 EXTRACTION OF LEHS										18.50*
068 CHEST X-RAY, SINGLE VIEW										28.50*
069 CHEST X-RAY, TWO VIEWS										35.00
070 X-RAY SPINE										28.50*
071 X-RAY HIP										65.00*
072 X-RAY UPPER GI TRACT										52.50*
073 X-RAY COLON										18.00*
074 RADIATION THERAPY-LOW VOLT										21.00*
075 RADIATION THERAPY-SUPER VOLT										95.00
076 RADIATION THERAPY-MEGAVOLT										60.00
077 CAT SCAN - HEAD										
078 CAT SCAN-HEAD, INTERPRET ONLY										
079 THREE CHEMISTRY TESTS										
080 TWELVE CHEMISTRY TESTS										
081 CULTURE-OTHER THAN BLOOD										
082 HEMOGLOBIN										
083 AUTOMATED BLOOD COUNT										
084 WHITE CELL COUNT										
085 COMPLETE BLOOD COUNT (CBC)										
086 CHOLESTEROL TEST										
087 FLOCCULATION TEST										
088 HEMATOCRIT										
089 PLATELET COUNT (REES-ECKER)										
090 POTASSIUM TEST										
091 PROTHROMBIN										
092 SEDIMENTATION RATE										
093 BLOOD SUGAR										
094 BUN-UREA, NITROGEN										
095 URIC ACID										
096 FECES-OCCULT BLOOD										
097 PAP TEST										
098 ROUTINE URINALYSIS										
099 CHEMICAL URINALYSIS										
100 PATHOLOGY-THREE SPECIMENS										

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

1979 PREVAILING CHARGE SUMMARY DATA

TEXAS

GROUP MEDICAL AND SURGICAL SERV.

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	770	790	770	790
001 INITIAL BRIEF OFFICE VISIT			14.30*	14.30*
002 INITIAL LIMITED OFFICE VISIT				
003 INIT INTERMED OFFICE VISIT				
004 INIT COMP OFFICE VISIT				
005 MINIMAL F/U OFFICE VISIT	30.00	30.00	49.90*	50.00
006 BRIEF F/U OFFICE VISIT	7.10*	7.10*	11.40*	8.60*
007 LIMITED F/U OFFICE VISIT	10.00	10.00	14.30*	11.40*
008 INTERMED F/U OFFICE VISIT	12.00	15.00	15.00	15.00
009 EXTENDED F/U OFFICE VISIT	20.00	20.00	15.00	30.00
010 COMPLETE F/U OFFICE VISIT	25.00*	25.00	35.70*	40.00
011 BRIEF F/U HOME VISIT	14.30*	14.30*	14.30*	14.30*
012 LIMITED F/U HOME VISIT			20.00	15.70*
013 INTERMEDIATE F/U HOME VISIT				
014 EXTENDED CARE FACILITY VISIT			67.50	67.70*
015 BRIEF F/U NURSING HOME VISIT	7.10*	7.10*	11.40*	8.60*
016 INITIAL BRIEF HOSPITAL VISIT	28.50*	21.40*	35.70*	35.70*
017 INIT INTERMED HOSPITAL VISIT			37.10*	40.00
018 INITIAL COMP HOSPITAL VISIT	35.70*	35.00	50.00	50.00
019 BRIEF F/U HOSPITAL VISIT	12.00	10.00	12.00	10.00
020 LIMITED F/U HOSPITAL VISIT	15.00	15.00	21.40	14.30*
021 INTERMED F/U HOSPITAL VISIT			25.00	15.00
022 EXTENDED F/U HOSPITAL VISIT			11.40*	8.60*
023 BRIEF EMERGENCY ROOM VISIT			14.30*	14.30*
024 LIMITED EMERGENCY ROOM VISIT			40.00	35.00
025 INTERMED EMERGENCY ROOM VISIT			35.70*	40.00
026 LIMITED CONSULTATION	35.70*	25.00	49.90*	50.00
027 EXTENSIVE CONSULTATION			50.00	45.00
028 COMPREHENSIVE CONSULTATION			28.50*	30.50*
029 PSYCHOTHERAPY-ONE HOUR			21.40*	20.00
030 PSYCHOTHERAPY-HALF HOUR			10.00	10.00
031 CHIROPRACTIC OFFICE VISIT	10.00	8.60*		
032 INITIAL PHYSIOTHERAPY				
033 F/U PODIATRIC OFFICE VISIT	21.40*	20.00	20.00	22.00
034 ELECTROCARDIOGRAM (EKG)				
035 EKG-INTERPRET.REPORT ONLY			26.50	
036 ARTERIAL BLOOD GAS STUDY				
037 ELECTROENCEPHALOGRAPH (EEG)			22.00	15.00
038 CHEMOTHERAPY				
039 COLLECTION OF SPECIMENS			17.10*	17.10*
040 DEBRIDEMENT OF NAILS			28.50*	15.00
041 SKIN BIOPSY			35.00	25.00
042 CHEMOCAUTERY			570.40*	641.70*
043 RADICAL MASTECTOMY			684.50*	713.00*
044 OPEN REDUCTION OF FRACTURE				
045 ARTROSCOPIC-MAJOR JOINT				
046 ARTHROTOMY				
047 ARTHROPLASTY-REPAIR OF HIP			27.00	17.00
048 NEEDLE PUNCTURE OF BURSA			1266.30*	1159.30*
049 BRONCHOSCOPY			20.00	19.30*
050 THORACENTESIS			195.00	142.60*
			50.00	50.00

1979 PREVAILING CHARGE SUMMARY DATA

TEXAS

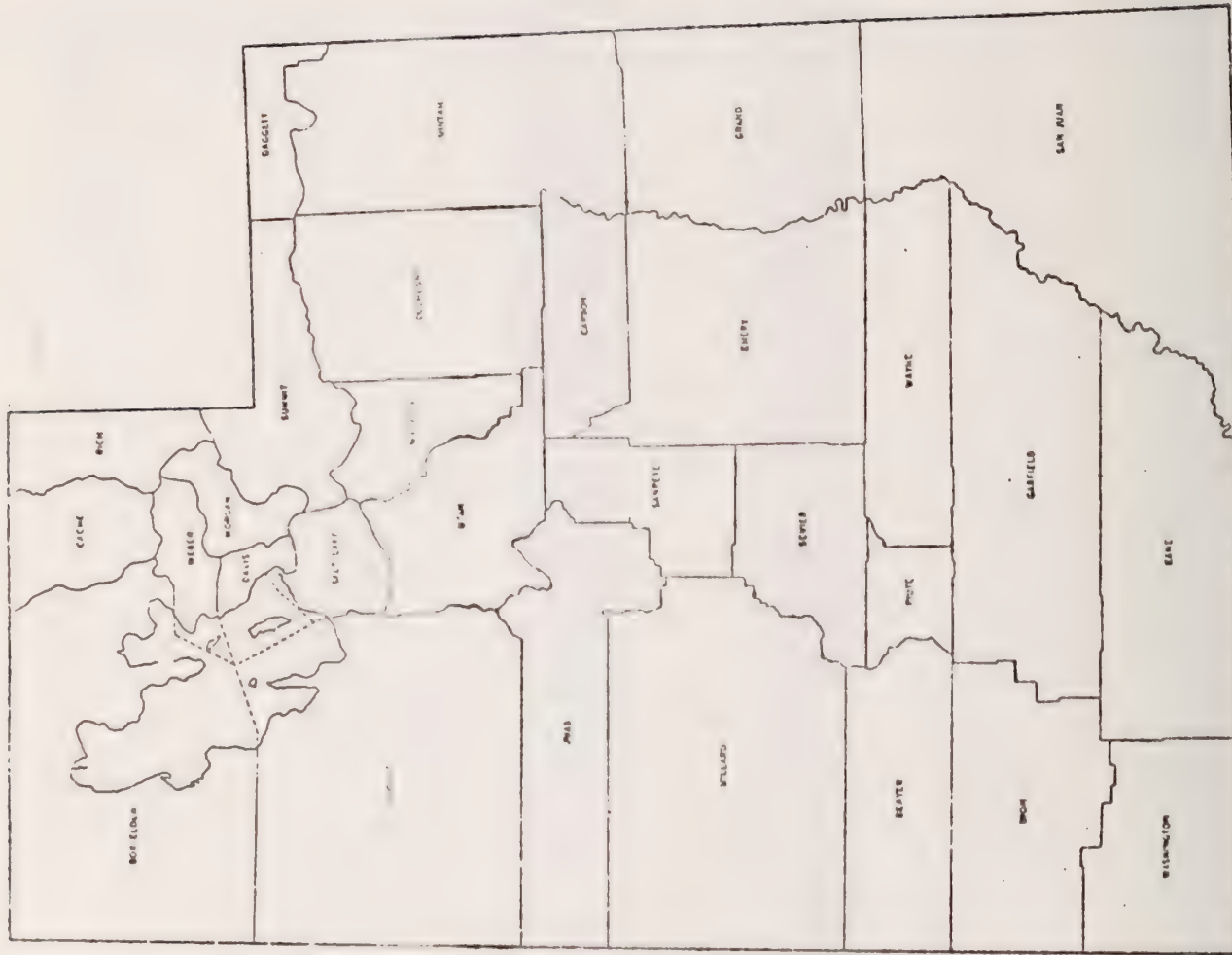
GROUP MEDICAL AND SURGICAL SERV.
LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	770	790	770	790
051 CATHETERIZATION OF HEART			427.80*	499.10*
052 INSERTION OF PACEMAKER			1083.80*	1083.80*
053 PARTIAL COLECTOMY			684.50*	650.25*
054 APPENDECTOMY			300.00*	265.20*
055 SIGMOIDOSCOPY	30.00	35.00	35.00	30.00
056 HEMORRHOIDECTOMY			171.10*	241.30*
057 CHOLECYSTECTOMY			499.10*	540.00
058 REPAIR HERNIA			320.90*	285.20*
059 DIAGNOSTIC CYSTOURETHROSCOPY		85.00	70.00	100.00
060 DILATION OF URETHRA			10.00	14.00
061 PROSTATECTOMY			641.70*	700.00
062 ELECTROSECTION-PROSTATE (TUR)		700.00	570.40*	695.00
063 HYSTERECTOMY			678.80*	638.80*
064 INITIAL COMPLETE EYE EXAM			28.50*	28.50*
065 COMPREHENSIVE EYE EXAM			10.00*	12.00
066 EYE EXAM WITH TONOMETRY			570.40*	606.10*
067 EXTRACTION OF LENS	673.10*	700.00	17.00	18.50*
068 CHEST X-RAY, SINGLE VIEW	17.50	17.00	25.00	25.00
069 CHEST X-RAY, TWO VIEWS	25.00	22.80	28.50*	32.00
070 X-RAY SPINE			24.00	24.00
071 X-RAY HIP			28.50*	32.00
072 X-RAY UPPER GI TRACT	3.00	15.00	24.00	24.00
073 X-RAY COLON			28.50*	64.20*
074 RADIATION THERAPY-LOW VOLT			45.30*	49.90*
075 RADIATION THERAPY-SUPER VOLT	15.00	14.50*	14.30*	12.50
076 RADIATION THERAPY-MECAVOLT	25.50	15.00	17.10*	15.00
077 CAT SCAN - HEAD			95.00	95.00
078 CAT SCAN-HEAD, INTERPRET ONLY			60.00	60.00
079 THREE CHEMISTRY TESTS				
080 TWELVE CHEMISTRY TESTS				
081 CULTURE-OTHER THAN BLOOD				
082 HEMOGLOBIN			13.00	13.00
083 AUTOMATED BLOOD COUNT			3.25	3.25
084 WHITE CELL COUNT			8.00	8.00
085 COMPLETE BLOOD COUNT (CBC)			3.25	3.25
086 CHOLESTEROL TEST			8.00	8.00
087 FLOCCULATION TEST			8.00	8.00
088 HEMATOCRIT			7.00	7.00
089 PLATELET COUNT (REES-ECKER)			3.00	3.00
090 POTASSIUM TEST			6.00	6.00
091 PROTHROMBIN			7.30	7.30
092 SEDIMENTATION RATE			6.50	6.50
093 BLOOD SUGAR			5.60	5.60
094 BUN-UREA NITROGEN			7.00	7.00
095 URIC ACID			8.00	8.00
096 FECES-OCCULT BLOOD			8.00	8.00
097 PAP TEST			4.00	4.00
098 ROUTINE URINALYSIS			7.90	7.90
099 CHEMICAL URINALYSIS			5.00	5.00
100 PATHOLOGY-THREE SPECIMENS			35.00	35.00

NOTE: For all laboratory services the carrier reported statewide screens for independent laboratories.

UTAH

UTAH



LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	01	01
001 INITIAL BRIEF OFFICE VISIT	15.00	15.00*
002 INITIAL LIMITED OFFICE VISIT		30.50*
003 INIT INTERMED OFFICE VISIT	30.00	30.50*
004 INIT COMP OFFICE VISIT	5.70*	41.30*
005 MINIMAL F/U OFFICE VISIT	8.30*	6.30*
006 BRIEF F/U OFFICE VISIT	11.00	8.60*
007 LIMITED F/U OFFICE VISIT	14.30*	12.80*
008 INTERMED F/U OFFICE VISIT	29.90*	15.00*
009 EXTENDED F/U OFFICE VISIT	30.00	30.50*
010 COMPLETE F/U OFFICE VISIT	14.30*	30.00*
011 BRIEF F/U HOME VISIT		15.00
012 LIMITED F/U HOME VISIT		15.00
013 INTERMEDIATE F/U HOME VISIT	17.75*	15.00
014 EXTENDED CARE FACILITY VISIT		15.40*
015 BRIEF F/U NURSING HOME VISIT	11.90*	8.00*
016 INITIAL BRIEF HOSPITAL VISIT	25.70*	25.00*
017 INIT INTERMED HOSPITAL VISIT		40.00*
018 INITIAL COMP HOSPITAL VISIT	59.90*	52.75*
019 BRIEF F/U HOSPITAL VISIT	11.90*	11.20*
020 LIMITED F/U HOSPITAL VISIT	15.00	13.00
021 INTERMED F/U HOSPITAL VISIT		22.10*
022 EXTENDED F/U HOSPITAL VISIT		28.80*
023 BRIEF EMERGENCY ROOM VISIT		20.80
024 LIMITED EMERGENCY ROOM VISIT		25.00*
025 INTERMED EMERGENCY ROOM VISIT	25.70*	25.00*
026 LIMITED CONSULTATION		42.50
027 EXTENSIVE CONSULTATION		60.70
028 COMPREHENSIVE CONSULTATION		42.80*
029 PSYCHOTHERAPY-ONE HOUR		21.30*
030 PSYCHOTHERAPY-HALF HOUR		9.70*
031 CHIROPRACTIC OFFICE VISIT	11.90*	
032 INITIAL PHYSIOTHERAPY		
033 F/U PODIATRIC OFFICE VISIT		10.00*
034 ELECTROCARDIOGRAM (EKG)	24.00	20.70
035 EKG-INTERPRET, REPORT ONLY	11.90*	7.00
036 ARTERIAL BLOOD GAS STUDY		
037 ELECTROENCEPHALOGRAM (EEG)		49.70*
038 CHEMOTHERAPY		18.80*
039 COLLECTION OF SPECIMENS		5.10
040 DEBRIDEMENT OF NAILS		10.00
041 SKIN BIOPSY		21.00*
042 CHEMOCAUTERY		17.10*
043 RADICAL MASTECTOMY		670.20*
044 OPEN REDUCTION OF FRACTURE		600.00
045 ARTHROCENTESIS-MAJOR JOINT		21.30*
046 ARTHROTOMY		20.00*
047 ARTHROPLASTY-REPAIR OF HIP	16.50	869.10*
048 NEEDLE PUNCTURE OF BURSA		19.60*
049 BRONCHOSCOPY		125.70*
050 THORACENTESIS		35.60*

1979 PREVAILING CHARGE SUMMARY DATA B/S OF UTAH

UTAH

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

01 01

PROCEDURE DESCRIPTION

051	CATHETERIZATION OF BLADDER	310.00*
052	AMBIENTION OF PRACTICER	500.00
053	INITIAL COLLECTORY	690.80*
054	PRONOSIS	200.00*
055	SIGMOIDOSCOPY	25.70*
056	ENDOSCOPIC COLONOSCOPY	242.40*
057	CHOLECYSTECTOMY	444.90*
058	HEPATIC HERNIA	305.50*
059	DIAGNOSTIC CYSTOURETHROSCOPY	57.00*
060	DILATION OF URETHRA	15.00
061	PROSTATECTOMY	560.00
062	ELECTROSECTION-PROSTATE (TURP)	570.40*
063	HYSTERECTOMY	539.50
064	INITIAL COMPLETE EYE EXAM	20.00
065	COMPREHENSIVE EYE EXAM	20.40
066	EYE EXAM WITH TONOMETRY	560.00
067	EXTRACTION OF LENS	18.00
068	CHEST X-RAY, SINGLE VIEW	26.40
069	CHEST X-RAY, TWO VIEWS	52.00
070	X-RAY SPINE	52.00
071	X-RAY HIP	40.00
072	X-RAY UPPER GI TRACT	45.00
073	X-RAY COLON	513.50
074	RADIATION THERAPY-LOW VOLT	16.00
075	RADIATION THERAPY-SUPER VOLT	24.50
076	RADIATION THERAPY-MEGAVOLT	40.00
077	CAT SCAN - HEAD	225.00
078	CAT SCAN-HEAD, INTERPRET ONLY	87.50
079	THREE CHEMISTRY TESTS	15.00
080	TWELVE CHEMISTRY TESTS	14.00
081	CULTURE-OTHER THAN BLOOD	15.00
082	ATROPHIC	3.50
083	ROUTED BLOOD COUNT	5.00
084	WHITE CELL COUNT	3.00
085	COMPLETE BLOOD COUNT (CBC)	8.00
086	CHOLESTEROL TEST	8.00
087	FLOCCULATION TEST	4.00
088	HEMATOCRIT	3.50
089	PLATELET COUNT (REES-ECKER)	5.50
090	POTASSIUM TEST	7.50
091	PROTHROMBIN	6.50
092	SEDIMENTATION RATE	4.25
093	BLOOD SUGAR	6.70
094	BUN-UREA-NITROGEN	7.00
095	URIC ACID	7.60
096	FECES-OCCULT BLOOD	4.00
097	COAG TEST	9.00
098	ROUTINE URINALYSIS	4.00
099	CHEMICAL URINALYSIS	3.00
100	PATHOLOGY-THREE SPECIMENS	8.70

VERMONT

VERMONT



PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	02		02	

001 INITIAL BRIEF OFFICE VISIT				001
002 INITIAL LIMITED OFFICE VISIT	12.00		15.00	002
003 INIT INTERMED OFFICE VISIT			25.00	003
004 INIT COMP OFFICE VISIT	35.00		35.70*	004
005 MINIMAL F/U OFFICE VISIT	5.00		6.00	005
006 BRIEF F/U OFFICE VISIT	10.00		11.40*	006
007 LIMITED F/U OFFICE VISIT			18.00	007
008 INTERMED F/U OFFICE VISIT	11.40*			008
009 EXTENDED F/U OFFICE VISIT			35.70*	009
010 COMPLETE F/U OFFICE VISIT	29.50*		15.00	010
011 BRIEF F/U HOME VISIT	14.00			011
012 LIMITED F/U HOME VISIT				012
013 INTERMEDIATE F/U HOME VISIT	20.00		16.00	013
014 EXTENDED CARE FACILITY VISIT			12.00	014
015 BRIEF F/U NURSING HOME VISIT	10.00		11.40*	015
016 INITIAL BRIEF HOSPITAL VISIT	25.00		35.00	016
017 INIT INTERMED HOSPITAL VISIT				017
018 INITIAL COMP HOSPITAL VISIT	35.00		40.00	018
019 BRIEF F/U HOSPITAL VISIT	9.40*		11.40*	019
020 LIMITED F/U HOSPITAL VISIT				020
021 INTERMED F/U HOSPITAL VISIT	12.00		14.00	021
022 EXTENDED F/U HOSPITAL VISIT			28.50*	022
023 BRIEF EMERGENCY ROOM VISIT			10.00*	023
024 LIMITED EMERGENCY ROOM VISIT			14.30*	024
025 INTERMED EMERGENCY ROOM VISIT				025
026 LIMITED CONSULTATION	30.00		35.00	026
027 EXTENSIVE CONSULTATION			36.40*	027
028 COMPREHENSIVE CONSULTATION			45.00	028
029 PSYCHOTHERAPY-ONE HOUR			40.00	029
030 PSYCHOTHERAPY-HALF HOUR			21.40*	030
031 CHIROPRACTIC OFFICE VISIT	10.00		10.00	031
032 INITIAL PHYSIOTHERAPY				032
033 F/U PODIATRIC OFFICE VISIT			10.00	033
034 ELECTROCARDIOGRAM (EKG)	18.00		19.40*	034
035 EKG-INTERPRET. REPORT ONLY	9.00			035
036 ARTERIAL BLOOD GAS STUDY			21.00	036
037 ELECTROENCEPHALOGRAM (EEG)			28.50*	037
038 CHEMOTHERAPY			12.00	038
039 COLLECTION OF SPECIMENS				039
040 DEBRIDEMENT OF NAILS			10.70*	040
041 SKIN BIOPSY			25.00	041
042 CHEMOCAUTERY				042
043 RADICAL WASTECTOMY			590.40*	043
044 OPEN REDUCTION OF FRACTURE			700.00	044
045 ARTHROCENTESIS-MAJOR JOINT			15.00	045
046 ARTHROTOMY			15.00	046
047 ARTHROPLASTY-REPAIR OF HIP			700.00	047
048 NEEDLE PUNCTURE OF BURSA			17.00	048
049 BRONCHOSCOPY			107.00*	049
050 THORACENTESIS			26.00	050

1979 PREVAILING CHARGE SUMMARY DATA NEW HAMPSHIRE-VERMONT B/S VERMONT

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE	LOCALITY DESIGNATION FOR SPECIALIST
	02	02
051 CATHETERIZATION OF HEART		270.00
052 INSERTION OF PACEMAKER		799.20
053 PARTIAL COLECTOMY		641.70*
054 APPENDECTOMY		330.00
055 SIGMOIDOSCOPY	20.00	25.00
056 HEMORRHOIDECTOMY		
057 CHOLECYSTECTOMY		479.00
058 REPAIR HERNIA		299.50*
059 DIAGNOSTIC CYSTOURETHROSCOPY	37.68	75.00*
060 DILATION OF URETHRA		28.50*
061 PROSTATECTOMY		684.50*
062 ELECTROSECTION-PROSTATE (TURP)	628.00	684.50*
063 HYSTRECTOMY		525.00
064 INITIAL COMPLETE EYE EXAM		17.10*
065 COMPREHENSIVE EYE EXAM		10.00
066 EYE EXAM WITH TONOMETRY	628.00	570.40*
067 EXTRACTION OF LENS	15.00	14.30
068 CHEST X-RAY, SINGLE VIEW	21.40	22.00
069 CHEST X-RAY, TWO VIEWS		25.00
070 X-RAY SPINE		22.00
071 X-RAY HIP		52.90*
072 X-RAY UPPER GI TRACT		49.90*
073 X-RAY COLON		8.60*
074 RADIATION THERAPY-LOW VOLT		17.10*
075 RADIATION THERAPY-SUPER VOLT		
076 RADIATION THERAPY-MEGAVOLT		
077 CAT SCAN - HEAD		
078 CAT SCAN-HEAD, INTERPRET ONLY		50.00
079 THREE CHEMISTRY TESTS		
080 TWELVE CHEMISTRY TESTS		
081 CULTURE-OTHER THAN BLOOD		
082 HEMOGLOBIN		4.00
083 AUTOMATED BLOOD COUNT		4.00
084 WHITE CELL COUNT		8.00
085 COMPLETE BLOOD COUNT (CBC)		4.00
086 CHOLESTEROL TEST		7.00
087 FLOCCULATION TEST		6.20
088 HEMATOCRIT		4.00
089 PLATELET COUNT (REES-ECKER)		3.00
090 POTASSIUM TEST		5.00
091 PROTHROMBIN		6.00
092 SEDIMENTATION RATE		5.00
093 BLOOD SUGAR		4.00
094 BUN-UREA-NITROGEN		5.50
095 URIC ACID		5.50
096 FECES-OCCULT BLOOD		5.50
097 PAP TEST		4.00
098 ROUTINE URINALYSIS		6.00
099 CHEMICAL URINALYSIS		4.00
100 PATHOLOGY-THREE SPECIMENS		2.00
		20.00

VIRGINIA

VIRGINIA



Four Localities:

01- Richmond metropolitan area and Charlottesville - Henrico, Chesterfield,

and Albemarle Counties.

02- Tidewater and Northern Virginia Counties - Loudon, Fauquier,

Prince William, James City, York Counties and the Suffolk, Portsmouth, Norfolk, Chesapeake, Virginia City area.

03- Small towns and industrial - Washington, Henry, Pittsylvania,

Halifax, Greensville, Campbell, Bedford, Roanoke,

Montgomery, Alleghany, Rockbridge, Augusta, Greene,

Rockingham, Page, Madison, Culpeper, Rappahannock,

Shenandoah, Warren, Frederick, Clarke, Stafford, and

Spotsylvania Counties.

04- Extremely rural - all other Counties.

(Note: Alexandria, Arlington, and Fairfax are carried by the

Washington D.C. carrier.)

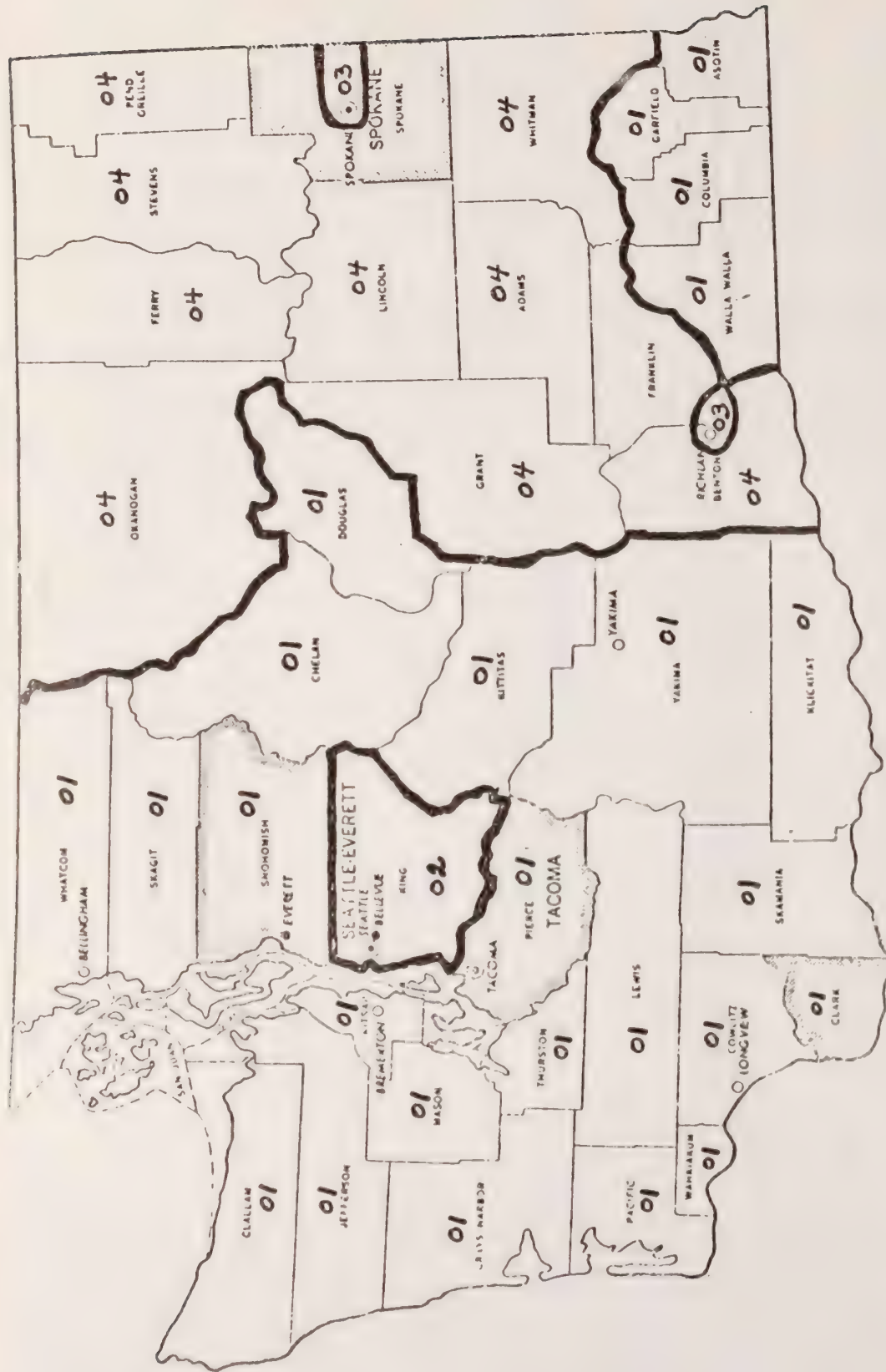
PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE				LOCALITY DESIGNATION FOR SPECIALIST			
	AREA 1	AREA 2	AREA 3	AREA 4	AREA 1	AREA 2	AREA 3	AREA 4
001 INITIAL BRIEF OFFICE VISIT	13.00	14.00	12.00	12.00	14.30*	14.30*	10.00*	10.00*
002 INITIAL LIMITED OFFICE VISIT					18.00	17.10*	14.30*	12.00
003 INIT INTERMED OFFICE VISIT	35.00	35.00	26.00	25.70*	25.00	35.00	20.00	20.00
004 INIT COMP OFFICE VISIT	10.00*	10.00*	8.60*	8.60*	49.90*	49.90*	35.60*	35.00
005 MINIMAL F/U OFFICE VISIT	10.00*	10.00*	8.60*	8.60*	14.30*	14.30*	10.00*	10.00*
006 BRIEF F/U OFFICE VISIT	13.00	14.00	12.00	12.00	14.30*	14.30*	10.00*	10.00*
007 LIMITED F/U OFFICE VISIT	15.00	20.00	23.00	15.00	25.00	35.00	20.00	20.00
008 INTERMED F/U OFFICE VISIT	15.00	20.00	23.00	15.00	25.00	35.00	20.00	20.00
009 EXTENDED F/U OFFICE VISIT	35.00	35.00	26.00	25.70*	49.90*	49.90*	35.60*	35.00
010 COMPLETE F/U OFFICE VISIT	14.30*	14.30*	14.30*	14.30*	20.00	20.00	14.30*	15.00
011 BRIEF F/U HOME VISIT	25.00	28.50*	15.00	20.00	21.30*	21.30*	20.00	15.00
012 LIMITED F/U HOME VISIT					25.00	17.10*	17.10*	17.10*
013 INTERMEDIATE F/U HOME VISIT	10.00*	10.00*	8.60	8.60*	9.00	9.00	8.00	
014 EXTENDED CARE FACILITY VISIT	35.60*	35.60*	28.50*	28.50*	14.30	14.30*	10.00	10.00
015 BRIEF F/U NURSING HOME VISIT					57.00*	49.90*	42.80*	40.00
016 INITIAL BRIEF HOSPITAL VISIT					57.00*	49.90*	42.80*	40.00
017 INIT INTERMED HOSPITAL VISIT	35.60*	35.60*	28.50*	28.50*	57.00*	49.90*	42.80*	40.00
018 INITIAL COMP HOSPITAL VISIT	12.80*	10.00*	8.60*	10.00*	14.30*	14.30*	10.00*	10.00*
019 BRIEF F/U HOSPITAL VISIT	17.10*	15.00	17.10*	18.60*	21.30*	21.30*	20.00*	19.00
020 LIMITED F/U HOSPITAL VISIT	21.30*	30.00	21.30*	25.70*	17.00	28.50*	25.00	25.70*
021 INTERMED F/U HOSPITAL VISIT					17.00	28.50*	25.00	25.70*
022 EXTENDED F/U HOSPITAL VISIT					14.30*	17.10*	14.30*	12.00
023 BRIEF EMERGENCY ROOM VISIT					25.00	20.00	15.00	15.00
024 LIMITED EMERGENCY ROOM VISIT					25.00	45.00	20.00	15.00
025 INTERMED EMERGENCY ROOM VISIT	23.50*	35.00	20.00	21.30*	30.00	40.00	25.00	35.60*
026 LIMITED CONSULTATION					42.80*	50.00	35.00	35.60*
027 EXTENSIVE CONSULTATION					57.00*	64.10*	49.90*	49.90*
028 COMPREHENSIVE CONSULTATION					35.60*	42.80*	35.60*	40.00
029 PSYCHOTHERAPY-ONE HOUR					21.30*	21.30*	16.00	10.00
030 PSYCHOTHERAPY-HALF HOUR					10.00	10.00*	10.00*	10.00*
031 CHIROPRACTIC OFFICE VISIT	10.00*	10.00*	8.60*	8.60*	11.30*			
032 INITIAL PHYSIOTHERAPY					21.30*	21.30*	19.00	17.90*
033 F/U PODIATRIC OFFICE VISIT	15.00	15.00	16.00	7.10*	10.70*	7.50	7.50	5.00
034 ELECTROCARDIOGRAM (EXG)								
035 EKG-INTERPRET-REPORT ONLY								
036 ARTERIAL BLOOD GAS STUDY								
037 ELECTROENCEPHALOGRAPH (EEG)								
038 CHEMOTHERAPY								
039 COLLECTION OF SPECIMENS								
040 DEBRIDEMENT OF NAILS								
041 SKIN BIOPSY								
042 CHEMOCAUTERY								
043 RADICAL MASTECTOMY								
044 OPEN REDUCTION OF FRACTURE								
045 ARTHROCENTESIS-MAJOR JOINT								
046 ARTHROTOMY								
047 ARTHROPLASTY-REPAIR OF HIP								
048 NEEDLE PUNCTURE OF BURSA								
049 BRONCHOSCOPY								
050 THORACENTESIS								

1979 PREVAILING CHARGE SUMMARY DATA THE TRAVELERS INSURANCE COMPANY VIRGINIA

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE				LOCALITY DESIGNATION FOR SPECIALIST			
	AREA 1	AREA 2	AREA 3	AREA 4	AREA 1	AREA 2	AREA 3	AREA 4
051 CATHETERIZATION OF HEART					250.00	320.80*	320.80*	
052 INSERTION OF PACEMAKER								
053 PARTIAL COLECTOMY					700.00	750.00	641.70*	647.40*
054 APPENDECTOMY					320.80*	342.10*	356.50*	299.50*
055 SIGMOIDOSCOPY					25.70*	35.60*	24.30*	35.00
056 HEMORRHOIDECTOMY					285.20*	285.20*	220.00	240.00
057 CHOLECYSTECTOMY					534.75*	560.00	499.10*	443.40*
058 REPAIR HERNIA					335.10*	356.50*	295.20*	285.20*
059 DIAGNOSTIC CYSTOURETHROSCOPY					42.80*	55.00	49.90*	49.90*
060 DILATION OF URETHRA					16.00	14.30*	14.30*	14.30*
061 PROSTATECTOMY					720.00	641.70*	640.00	499.10*
062 ELECTROSECTION-PROSTATE (TUR)					684.50*	684.50*	641.70*	442.10*
063 HYSTERECTOMY					499.10*	677.30*	533.30*	533.30*
064 INITIAL COMPLETE EYE EXAM								
065 COMPREHENSIVE EYE EXAM					21.30*	20.00*	20.00*	21.30*
066 EYE EXAM WITH TONOMETRY								
067 EXTRACTION OF LENS					641.70*	570.40*	550.00	606.00*
068 CHEST X-RAY, SINGLE VIEW					18.00	14.00	14.30*	22.80*
069 CHEST X-RAY, TWO VIEWS					18.00	21.00	21.30*	24.90*
070 X-RAY SPINE					37.70*	41.00	35.60*	37.70*
071 X-RAY HIP					24.00	28.00	28.50*	28.50*
072 X-RAY UPPER GI TRACT					50.00	56.00	57.00*	57.00*
073 X-RAY COLON					45.00	49.00	49.90*	49.00
074 RADIATION THERAPY-LOW VOLT								
075 RADIATION THERAPY-SUPER VOLT								
076 RADIATION THERAPY-NEGAVOLT								
077 CAT SCAN - HEAD					150.00	150.00	150.00	150.00
078 CAT SCAN-HEAD, INTERPRET ONLY					75.00	75.00	75.00	75.00
079 THREE CHEMISTRY TESTS					15.00	16.00	16.00	
080 TWELVE CHEMISTRY TESTS					20.00	20.00	12.00	
081 CULTURE-OTHER THAN BLOOD					10.00	10.00	10.00	
082 HEMOGLOBIN					3.00	4.00	3.00	
083 AUTOMATED BLOOD COUNT					10.00	10.00	8.00	
084 WHITE CELL COUNT					3.50	5.00	3.00	
085 COMPLETE BLOOD COUNT (CBC)					10.00	10.00	8.00	
086 CHOLESTEROL TEST					6.00	6.00	6.00	
087 FLOCCULATION TEST					5.00	6.00	3.00	
088 HEMATOCRIT					4.00	4.00	3.00	
089 PLATELET COUNT (REES-ECKER)					7.00	6.00	5.00	
090 POTASSIUM TEST					6.00	5.00	6.00	
091 PROTHROMBIN					6.00	5.00	5.00	
092 SEDIMENTATION RATE					5.00	5.00	4.00	
093 BLOOD SUGAR					6.00	6.00	5.00	
094 BUN-UREA-NITROGEN					6.00	5.50	5.00	
095 URIC ACID					6.00	6.00	7.00	
096 FECES-OCULT BLOOD					5.00	3.00	3.00	
097 PAP TEST					6.00	7.50	7.00	7.50
098 ROUTINE URINALYSIS					5.00	5.00	4.00	
099 CHEMICAL URINALYSIS					1.00	1.00	1.00	
100 PATHOLOGY-THREE SPECIMENS					20.00	18.00	15.00	20.00

WASHINGTON

WASHINGTON



Four Localities:

- 01 - Seattle-Washington Physicians Service, 18 bureaus - rest of State
- 02 - King County Medical Blue Shield - King County
- 03 - (NSCW) - Spokane and Richland-Pasco-Kennewick metropolitan areas
- 04 - Medical Service Corporation of Eastern Washington - Adams, Benton, Ferry, Franklin, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman Counties

(ON NATIONAL PRACTITIONER ONLY)

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

02 04 01 03

02 04 01 03

001 INITIAL BRIEF OFFICE VISIT	14.30*	14.90	14.30*	14.30*	14.30	001
002 INITIAL LIMITED OFFICE VISIT				14.30*	14.30	002
003 INIT INTERMED OFFICE VISIT				15.00	24.60*	003
004 INIT COMP OFFICE VISIT	42.80*	34.90	42.80*	27.80*	35.60*	004
005 MINIMAL F/U OFFICE VISIT	7.10*	5.60	7.10	49.90*	53.50*	005
006 BRIEF F/U OFFICE VISIT	11.30*	10.00	10.00*	7.10	5.00	006
007 LIMITED F/U OFFICE VISIT	15.00		12.60*	12.20*	11.50	007
008 INTERMED F/U OFFICE VISIT	16.00	25.00	15.50*	14.30*	14.75*	008
009 EXTENDED F/U OFFICE VISIT	20.00	16.00	25.20*	17.20*	20.00	009
010 COMPLETE F/U OFFICE VISIT	35.60*		38.70*	26.00	41.30	010
011 BRIEF F/U HOME VISIT	21.40*	18.10	17.10*	35.60*	44.25*	011
012 LIMITED F/U HOME VISIT					17.10*	012
013 INTERMEDIATE F/U HOME VISIT	25.00		26.25		24.00	013
014 EXTENDED CARE FACILITY VISIT					11.50	014
015 BRIEF F/U NURSING HOME VISIT	14.30*	10.00	12.50		18.10	015
016 INITIAL BRIEF HOSPITAL VISIT	35.00	27.10	27.10*		19.25*	016
017 INIT INTERMED HOSPITAL VISIT				12.20	15.30*	017
018 INITIAL COMP HOSPITAL VISIT	42.80*	38.50	51.40*	14.30	11.10*	018
019 BRIEF F/U HOSPITAL VISIT	14.30	10.00	10.00*	30.00	10.00	019
020 LIMITED F/U HOSPITAL VISIT	14.30*		15.00	35.60*	42.80	020
021 INTERMED F/U HOSPITAL VISIT	13.00		24.00	49.90*	54.90	021
022 EXTENDED F/U HOSPITAL VISIT				14.30	14.30	022
023 BRIEF EMERGENCY ROOM VISIT				14.30*	17.10*	023
024 LIMITED EMERGENCY ROOM VISIT				20.00	27.50	024
025 INTERMED EMERGENCY ROOM VISIT				26.00		025
026 LIMITED CONSULTATION	30.00	25.10	28.00		18.70	026
027 EXTENSIVE CONSULTATION				19.40*	21.40*	027
028 COMPREHENSIVE CONSULTATION				19.40*	31.10*	028
029 PSYCHOTHERAPY-ONE HOUR				28.50*	35.00	029
030 PSYCHOTHERAPY-HALF HOUR				35.60*	50.00*	030
031 CHIROPRACTIC OFFICE VISIT	12.00	11.50		49.90*	64.10*	031
032 INITIAL PHYSIOTHERAPY				42.80*	45.60*	032
033 F/U PODIATRIC OFFICE VISIT				21.40*	21.40*	033
034 ELECTROCARDIOGRAM (EKG)	24.00	26.60	25.70*	12.00	11.50	034
035 EKG-INTERPRET-REPORT ONLY	8.00	10.70	11.80*	24.00	25.00	035
036 ARTERIAL BLOOD GAS STUDY				8.00	11.80	036
037 ELECTROENCEPHALOGRAPH (EEG)				18.00	6.00	037
038 CHEMOTHERAPY					54.90	038
039 COLLECTION OF SPECIMENS					15.00	039
040 DEBRIDEMENT OF NAILS				3.00	4.70	040
041 SKIN BIOPSY				20.00	12.80*	041
042 CHEMOCAUTERY				26.00	25.00	042
043 RADICAL WASTECTOMY				21.40*	24.90*	043
044 OPEN REDUCTION OF FRACTURE				834.40*	599.10*	044
045 ARTHROCENTESIS-MAJOR JOINT				773.00*	796.80*	045
046 ARTHROTOMY					22.00*	046
047 ARTHROPLASTY-REPAIR OF HIP				24.40*	22.85	047
048 NEEDLE PUNCTURE OF BURSA				886.00*	1239.80*	048
049 BRONCHOSCOPY				21.40*	17.55	049
050 THORACENTESIS				175.60*	142.60	050
				35.00	34.20*	

1979 PREVAILING CHARGE SUMMARY DATA WASHINGTON PHYSICIANS SERVICE WASHINGTON

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE			LOCALITY DESIGNATION FOR SPECIALIST		
	02	04	01	02	04	01
051 CATHETERIZATION OF HEART				520.00		288.20*
052 INSERTION OF PACEMAKER						749.23*
053 PARTIAL COLECTOMY				855.30*		763.20*
054 APPENDECTOMY						380.00
055 SIGMOIDOSCOPY				35.00		29.90*
056 HEMORRHOIDECTOMY				285.30*		299.50*
057 CHOLECYSTECTOMY				599.10*		570.40
058 REPAIR HERNIA				356.60*		349.60*
059 DIAGNOSTIC CYSTOURETHROSCOPY				42.80		50.40
060 DILATION OF URETHRA				20.00		23.00
061 PROSTATECTOMY				798.80*		774.00
062 ELECTROSECTION-PROSTATE (TUR)				734.60*		798.80*
063 HYSTERECTOMY				22.80*		684.70*
064 INITIAL COMPLETE EYE EXAM						28.00
065 COMPREHENSIVE EYE EXAM				11.30*		28.00
066 EYE EXAM WITH TONOMETRY				713.20*		12.80*
067 EXTRACTION OF LENS				20.00		713.20*
068 CHEST X-RAY, SINGLE VIEW				25.00*		14.30*
069 CHEST X-RAY, TWO VIEWS				45.00		26.50
070 X-RAY SPINE						28.50*
071 X-RAY HIP				29.30*		33.00
072 X-RAY UPPER GI TRACT				59.90*		28.50
073 X-RAY COLON				64.10*		57.10*
074 RADIATION THERAPY-LOW VOLT				31.50		54.20*
075 RADIATION THERAPY-SUPER VOLT						22.00
076 RADIATION THERAPY-MEGAVOLT						
077 CAT SCAN - HEAD						
078 CAT SCAN-HEAD, INTERPRET ONLY						
079 THREE CHEMISTRY TESTS						
080 TWELVE CHEMISTRY TESTS						
081 CULTURE-OTHER THAN BLOOD						
082 HEMOGLOBIN						
083 AUTOMATED BLOOD COUNT						
084 WHITE CELL COUNT						
085 COMPLETE BLOOD COUNT (CBC)						
086 CHOLESTEROL TEST						
087 FLOCCULATION TEST						
088 HEMATOCRIT						
089 PLATELET COUNT (REES-ECKER)						
090 POTASSIUM TEST						
091 PROTHROMBIN						
092 SEDIMENTATION RATE						
093 BLOOD SUGAR						
094 BUN-UREA-NITROGEN						
095 URIC ACID						
096 FECES-OCULT BLOOD						
097 PAP TEST						
098 ROUTINE URINALYSIS						
099 CHEMICAL URINALYSIS						
100 PATHOLOGY-THREE SPECIMENS						

WEST VIRGINIA

Five Localities:

- 16 - Charleston
- 17 - Wheeling
- 18 - Eastern Valley
- 19 - Ohio River Valley
- 20 - Southern Valley

Five Localities:
16 - Charleston
17 - Wheeling
18 - Eastern Valley
19 - Ohio River Valley
20 - Southern Valley

DATA NATIONWIDE MUTUAL INSURANCE CO.

565

1979 PREVAILING CHARGE SUMMARY DATA

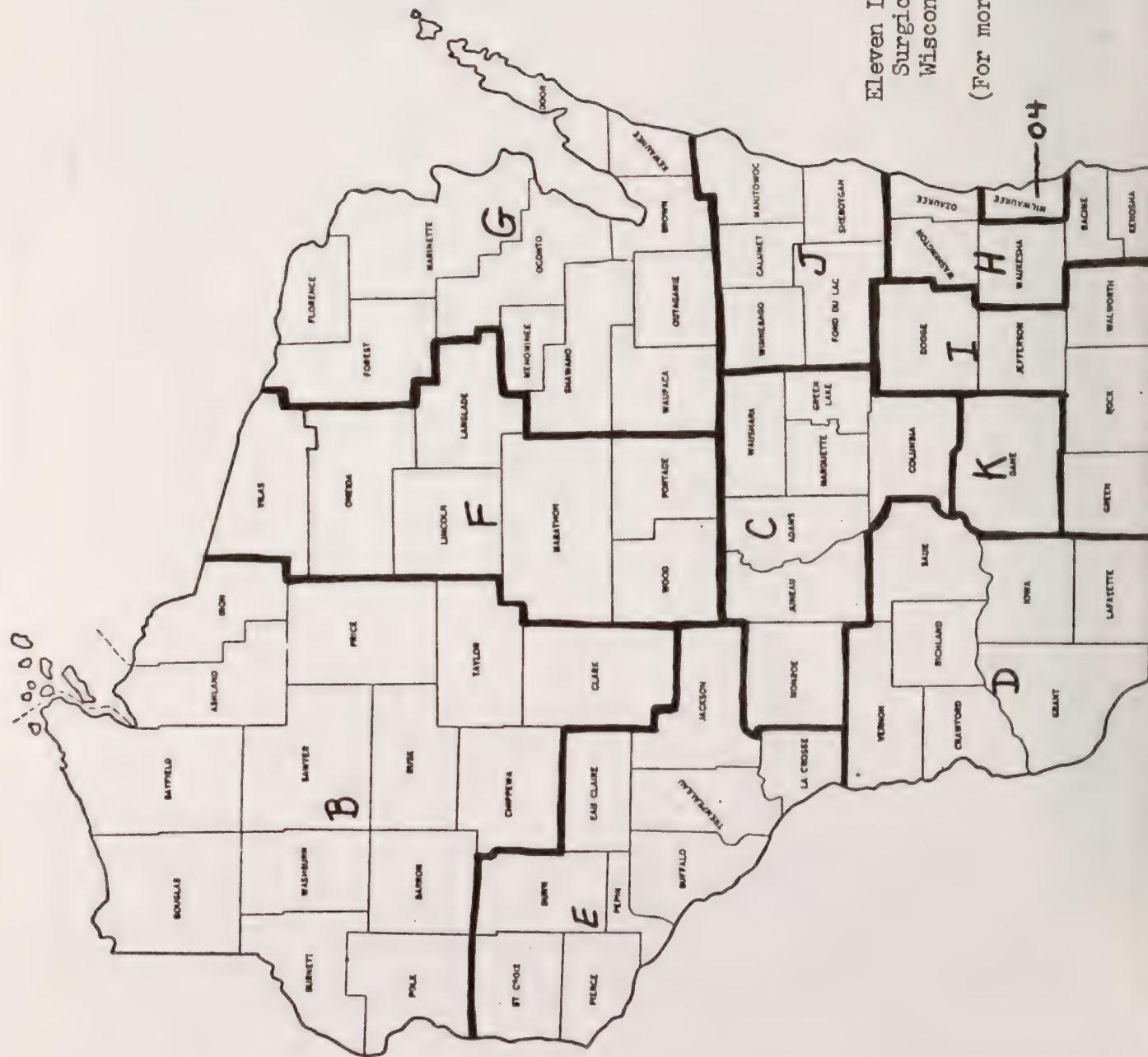
WEST VIRGINIA

NATIONWIDE MUTUAL INSURANCE CO.

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE					LOCALITY DESIGNATION FOR SPECIALISTS				
	16	17	18	19	20	16	17	18	19	20
051 CATHETERIZATION OF HEART						427.80*	427.80*	427.80*	427.80*	427.80*
052 INSERTION OF PACEMAKER						570.40*	713.00*	845.00	845.00	845.00
053 PARTIAL COLECTOMY						700.00	600.00*	713.00*	700.00	713.00*
054 APPENDECTOMY						356.50*	356.50*	356.50*	356.50*	356.50*
055 SIGMOIDOSCOPY	35.00	28.50*	28.50*	35.70*	23.25	35.70*	21.40*	30.00	28.50*	28.50*
056 HEMORRHOIDECTOMY						350.00	350.00*	350.00	350.00	350.00
057 CHOLECYSTECTOMY						534.75*	427.80*	570.40*	434.80*	427.80*
058 REPAIR HERNIA						320.90*	285.20*	356.50*	320.90*	285.20*
059 DIAGNOSTIC CYSTOURETHROSCOPY	45.00	45.00	45.00	45.00	45.00	45.00*	49.90*	60.00	28.50*	51.30*
060 DILATION OF URETHRA						20.00	14.30*	17.10*	14.30*	17.10*
061 PROSTATECTOMY						684.50*	684.50*	684.50*	570.40*	624.50*
062 ELECTROSECTION-PROSTATE (TUR)	499.10*	499.10*	499.10*	499.10*	499.10*	684.50*	684.50*	570.40*	570.40*	606.10*
063 HYSTERECTOMY						641.70*	641.70*	641.70*	641.70*	641.70*
064 INITIAL COMPLETE EYE EXAM						22.00	24.00	22.80*	21.40*	22.80*
065 COMPREHENSIVE EYE EXAM						28.00	24.00	22.80*	21.40*	22.80*
066 EYE EXAM WITH TOMOMETRY						14.30*	15.00	15.00	10.00	14.30*
067 EXTRACTION OF LENS	570.40*	570.40*	616.00*	570.40*	570.40*	570.40*	570.40*	616.00*	570.49*	556.10*
068 CHEST X-RAY, SINGLE VIEW	17.10*	20.00*	20.00*	25.00*	21.00	15.00*	21.00*	11.40*	20.00	17.10*
069 CHEST X-RAY, TWO VIEWS	21.40*	21.40*	21.40*	25.00*	21.40*	21.40*	24.00	14.30*	21.40*	21.40*
070 X-RAY SPINE						40.00	40.00	40.00	40.00	40.00
071 X-RAY HIP						25.70*	25.70*	25.70*	21.40*	34.50
072 X-RAY UPPER GI TRACT	35.70*	35.70*	35.70*	45.00*	40.00*	35.70*	42.00*	28.50*	49.90*	57.00*
073 X-RAY COLON						42.80*	32.10*	28.50*	49.90*	49.90*
074 RADIATION THERAPY-LOW VOLT	17.80*	17.80*	17.80*	20.00	17.80*	17.80*	17.80*	17.80*	12.60*	17.80*
075 RADIATION THERAPY-SUPER VOLT	17.80*	25.70*	25.70*	36.00	25.70*	17.80*	25.70*	25.70*	36.00	25.70*
076 RADIATION THERAPY-MEGAVOLT						30.00	31.00	30.00	30.00	30.00
077 CAT SCAN - HEAD						150.00	150.00*	150.00*	150.00	150.00*
078 CAT SCAN-HEAD, INTERPRET ONLY										
079 THREE CHEMISTRY TESTS	1.20	1.25	1.30	1.25		1.20	1.25	1.30	1.25	1.70
080 TWELVE CHEMISTRY TESTS	11.50	15.00	12.00	12.00		11.50	15.00	12.00	12.00	11.50
081 CULTURE-OTHER THAN BLOOD	4.00	4.00	4.00	5.00		4.00	4.00	4.00	5.00	4.00
082 HEMOGLOBIN										
083 AUTOMATED BLOOD COUNT										
084 WHITE CELL COUNT	4.00	3.00	3.50	5.00		4.00	3.00	3.50	5.00	4.00
085 COMPLETE BLOOD COUNT (CBC)	9.00	12.00	7.00	10.00		9.00	12.00	7.00	10.00	8.50
086 CHOLESTEROL TEST	8.00	5.00	6.00	7.00		8.00	5.00	6.00	7.00	8.00
087 FLOCCULATION TEST	10.00	5.00	5.00	6.00		10.00	5.00	5.00	6.00	7.00
088 HEMATOCRIT	4.00	4.00	2.00	3.50		4.00	4.00	2.00	3.50	3.00
089 PLATELET COUNT (REES-ECKER)	5.00	5.00	5.75	6.00		5.00	5.00	5.75	6.00	6.00
090 POTASSIUM TEST	7.00	7.00	7.00	8.00		7.00	7.00	7.00	8.00	8.00
091 PROTHROMBIN	6.00	5.50	5.00	6.00		6.00	5.50	5.00	6.00	6.00
092 SEDIMENTATION RATE	5.00	5.00	5.00	4.00		5.00	5.00	5.00	4.00	6.00
093 BLOOD SUGAR	7.00	6.00	6.00	7.00		7.00	6.00	6.00	7.00	7.00
094 BUN-UREA, NITROGEN	9.00	7.00	6.00	7.00		9.00	7.00	6.00	7.00	8.00
095 URIC ACID	3.00	1.70	2.00	1.50		3.00	1.70	2.00	1.50	2.00
096 FECES-CCULT BLOOD	8.00	10.00	8.00	7.00		8.00	10.00	8.00	7.00	10.00
097 PAP TEST	4.00	5.00	4.00	5.00		4.00	5.00	4.00	5.00	5.00
098 ROUTINE URINALYSIS	3.00	4.00	3.75	3.75		3.00	4.00	3.75	3.75	3.00
099 CHEMICAL URINALYSIS										
100 PATHOLOGY-THREE SPECIMENS	15.00	20.00	18.00	20.00		15.00	20.00	18.00	20.00	15.80

WINCONSIN

WISCONSIN



Eleven Localities:

Surgical Care - Blue Shield Wisconsin - 04
 Wisconsin Physicians Service - B, C, D, E, F,
 G, H, I, J, K
 (For more locality information see Appendix A)

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	04	04
001 INITIAL BRIEF OFFICE VISIT		10.50
002 INITIAL LIMITED OFFICE VISIT	12.00	15.00
003 INIT INTERMED OFFICE VISIT		15.00
004 INIT COMP OFFICE VISIT	25.00	49.90*
005 MINIMAL F/U OFFICE VISIT	10.50	10.50
006 BRIEF F/U OFFICE VISIT	10.50	10.50
007 LIMITED F/U OFFICE VISIT	12.00	15.00
008 INTERMED F/U OFFICE VISIT	15.00	15.00
009 EXTENDED F/U OFFICE VISIT	15.00	15.00
010 COMPLETE F/U OFFICE VISIT	25.00	49.90*
011 BRIEF F/U HOME VISIT	20.00	20.00
012 LIMITED F/U HOME VISIT		20.00
013 INTERMEDIATE F/U HOME VISIT	20.00	20.00
014 EXTENDED CARE FACILITY VISIT		14.30*
015 BRIEF F/U NURSING HOME VISIT	12.00	14.30*
016 INITIAL BRIEF HOSPITAL VISIT	33.50*	38.60*
017 INIT INTERMED HOSPITAL VISIT		38.60*
018 INITIAL COMP HOSPITAL VISIT	49.90*	49.90*
019 BRIEF F/U HOSPITAL VISIT	14.30*	14.40*
020 LIMITED F/U HOSPITAL VISIT	14.30*	15.00*
021 INTERMED F/U HOSPITAL VISIT		25.00
022 EXTENDED F/U HOSPITAL VISIT		18.48
023 BRIEF EMERGENCY ROOM VISIT		21.40*
024 LIMITED EMERGENCY ROOM VISIT		42.00
025 INTERMED EMERGENCY ROOM VISIT	42.00*	49.90*
026 LIMITED CONSULTATION		71.30*
027 EXTENSIVE CONSULTATION		49.00
028 COMPREHENSIVE CONSULTATION		25.50
029 PSYCHOTHERAPY-ONE HOUR		9.00
030 PSYCHOTHERAPY-HALF HOUR	8.90*	14.00
031 CHIROPRACTIC OFFICE VISIT		25.00
032 INITIAL PHYSIOTHERAPY		6.00
033 F/U PODIATRIC OFFICE VISIT	30.00	1.30*
034 ELECTROCARDIOGRAM (EKG)	5.80	28.00
035 EKG-INTERPRET, REPORT ONLY		15.60
036 ARTERIAL BLOOD GAS STUDY		27.50
037 ELECTROENCEPHALOGRAM (EEG)		9.00
038 CHEMOTHERAPY		641.70*
039 COLLECTION OF SPECIMENS		684.50
040 DEBRIDEMENT OF NAILS		25.00
041 SKIN BIOPSY		25.00
042 CHEMOCAUTERY		25.00
043 RADICAL WASTECTOMY		25.00
044 OPEN REDUCTION OF FRACTURE		25.00
045 ARTHROCENTESIS-MAJOR JOINT		25.00
046 ARTHROTOMY	18.00	25.00
047 ARTHROPLASTY-REPAIR OF HIP		36.00
048 NEEDLE PUNCTURE OF BURSA		213.90*
049 BRONCHOSCOPY		50.00*
050 THORACENTESIS		

1979 PREVAILLING CHARGE SUMMARY DATA

MEDICAL SOCIETY OF MILWAUKEE CO.

WISCONSIN

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION	04	04
051 CATHETERIZATION OF HEART		356.50*
052 INSERTION OF PACEMAKER		426.50
053 PARTIAL COLECTOMY		819.90*
054 APPENDECTOMY		384.00
055 SIGMOIDOSCOPY	45.00	45.00
056 HEMORRHOIDECTOMY		315.00
057 CHOLECYSTECTOMY		534.75*
058 REPAIR HERNIA		325.10*
059 DIAGNOSTIC CYSTOURETHROSCOPY	74.00	68.00
060 DILATION OF URETHRA		10.00
061 PROSTATECTOMY		698.70*
062 ELECTROSECTION-PROSTATE (TUR)	646.90*	634.50*
063 HYSTERECTOMY		641.70*
064 INITIAL COMPLETE EYE EXAM		20.80
065 COMPREHENSIVE EYE EXAM		15.00
066 EYE EXAM WITH TONOMETRY		713.00*
067 EXTRACTION OF LENS	592.00	18.60
068 CHEST X-RAY, SINGLE VIEW	17.10	22.80*
069 CHEST X-RAY, TWO VIEWS	25.70	42.80*
070 X-RAY SPINE		28.00
071 X-RAY HIP		28.00
072 X-RAY UPPER GI TRACT	57.00*	45.60*
073 X-RAY COLON		42.80*
074 RADIATION THERAPY-LOW VOLT		23.00
075 RADIATION THERAPY-SUPER VOLT	17.80	14.30*
076 RADIATION THERAPY-MEGAVOLT	17.80	14.30*
077 CAT SCAN - HEAD		161.20
078 CAT SCAN-HEAD, INTERPRET ONLY		61.20
079 THREE CHEMISTRY TESTS		32.00
080 TWELVE CHEMISTRY TESTS		24.00
081 CULTURE-OTHER THAN BLOOD		17.70*
082 HEMOGLOBIN		4.20*
083 AUTOMATED BLOOD COUNT		5.25
084 WHITE CELL COUNT		4.20*
085 COMPLETE BLOOD COUNT (CBC)		15.00
086 CHOLESTEROL TEST		8.00
087 FLOCCULATION TEST		10.30
088 HEMATOCRIT		4.50
089 PLATELET COUNT (REES-ECKER)		9.50
090 POTASSIUM TEST		8.25
091 PROTHROMBIN		7.70*
092 SEDIMENTATION RATE		5.50
093 BLOOD SUGAR		7.50
094 BUN-UREA-NITROGEN		8.00
095 URIC ACID		8.00
096 FECES-OCCULT BLOOD		4.75
097 PAP TEST		9.00
098 ROUTINE URINALYSIS		6.00
099 CHEMICAL URINALYSIS		5.90*
100 PATHOLOGY-THREE SPECIMENS		16.00

NOTE: For all laboratory services the carrier reported statewide screens for independent

1979 PREVAILING CHARGE SUMMARY DATA

WISCONSIN PHYSICIANS SERVICE

WISCONSIN

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

B-12 C-13 D-14 K-15 E-19 B-12 C-13 D-14 K-15 E-19

001 INITIAL BRIEF OFFICE VISIT	21.40*	21.40*	23.00	23.00	23.00	14.30*	14.30*	16.50	20.00	18.00	001
002 INITIAL LIMITED OFFICE VISIT						35.00	21.40*	35.70*	35.00	35.70*	002
003 INIT INTERMED OFFICE VISIT						35.00	21.40*	35.70*	35.00	35.70*	003
004 INIT COMP OFFICE VISIT	24.70*	23.00*	30.00	30.00	30.00	41.20*	38.40*	49.90*	49.90*	49.90*	004
005 MINIMAL F/U OFFICE VISIT	4.30*	4.00	4.30*	5.00	4.30*	5.00	4.30*	5.70*	7.10	5.30*	005
006 BRIEF F/U OFFICE VISIT	8.60*	8.60*	8.60*	8.60*	8.60*	8.60*	10.00*	10.00*	11.40*	10.30	006
007 LIMITED F/U OFFICE VISIT	11.40*	10.50	9.00	12.00	12.10*	10.70*	10.00*	11.40*	14.30*	14.10	007
008 INTERMED F/U OFFICE VISIT	14.30*	14.30*	14.30*	15.00	14.30*	14.30*	14.30*	18.00	20.00	22.80*	008
009 EXTENDED F/U OFFICE VISIT	18.00	21.40*	20.00	25.00	22.50	25.00	21.40*	30.00	28.50*	22.50	009
010 COMPLETE F/U OFFICE VISIT	21.40*	34.20*	25.70*	20.00	26.00	23.90*	32.60*	35.70*	35.70*	35.70*	010
011 BRIEF F/U HOME VISIT	11.40*	14.30*	14.30*	17.10*	14.30*	11.40*	14.30*	14.30*	17.10*	14.30*	011
012 LIMITED F/U HOME VISIT						14.30*	21.40*	21.40*	21.40*	21.40*	012
013 INTERMEDIATE F/U HOME VISIT	15.00	21.40*	21.40*	21.40*	21.40*	14.30*	21.40*	21.40*	21.40*	21.40*	013
014 EXTENDED CARE FACILITY VISIT						14.30*	10.70*	7.10*	17.10*	7.10*	014
015 BRIEF F/U NURSING HOME VISIT	10.00	10.70*	8.60*	10.20	11.40*	10.50	10.00	7.10*	15.00	10.00	015
016 INITIAL BRIEF HOSPITAL VISIT	25.70*	21.40*	21.40*	30.00*	21.40*	25.70*	21.40*	35.70*	49.90*	35.70*	016
017 INIT INTERMED HOSPITAL VISIT						50.00	35.70*	49.90*	51.00	36.00	017
018 INITIAL COMP HOSPITAL VISIT	60.00	52.00	40.00	52.00	51.30*	50.00	43.00*	50.00	56.00	43.00	018
019 BRIEF F/U HOSPITAL VISIT	8.60*	8.60*	8.30*	8.60*	8.60*	8.60*	7.00	8.60*	11.40*	10.00*	019
020 LIMITED F/U HOSPITAL VISIT	14.00	14.30*	11.40*	14.30*	14.30*	12.00	11.40*	11.40*	14.50	14.00	020
021 INTERMED F/U HOSPITAL VISIT	14.00	14.30*	11.40*	14.30*	14.30*	12.00	11.40*	11.40*	14.50	14.00	021
022 EXTENDED F/U HOSPITAL VISIT						35.70*	30.70*	40.00	35.00	34.30*	022
023 BRIEF EMERGENCY ROOM VISIT											023
024 LIMITED EMERGENCY ROOM VISIT											024
025 INTERMED EMERGENCY ROOM VISIT	20.00	14.30*	14.30*	20.00	20.00	20.00	15.00	25.00	24.20	23.00	025
026 LIMITED CONSULTATION						35.70*	42.80*	49.90*	49.90*	45.60*	026
027 EXTENSIVE CONSULTATION						61.90*	42.80*	49.90*	50.00	75.00	027
028 COMPREHENSIVE CONSULTATION						49.90*	49.90*	49.90*	50.00	49.90*	028
029 PSYCHOTHERAPY-ONE HOUR						24.70*	23.00*	24.00*	38.90	23.10*	029
030 PSYCHOTHERAPY-HALF HOUR						8.00	8.00	8.00	8.00	8.00	030
031 CHIROPRACTIC OFFICE VISIT						16.50	9.20*	12.00*	25.00	17.10*	031
032 INITIAL PHYSIOTHERAPY						10.00*	10.00*	10.00*	10.00*	10.00*	032
033 F/U PODIATRIC OFFICE VISIT						24.10	24.10	24.10	24.10	24.10	033
034 ELECTROCARDIOGRAM (EKG)	24.10	19.90	24.10	24.10	24.10	5.00	7.00	7.10*	6.00	10.00*	034
035 EKG-INTERPRET. REPORT ONLY	7.10*	7.00	6.00	7.00	6.50						035
036 ARTERIAL BLOOD GAS STUDY						55.00	55.00	55.00	55.00	55.00	036
037 ELECTROENCEPHALOGRAM (EEG)											037
038 CHEMOTHERAPY											038
039 COLLECTION OF SPECIMENS											039
040 DEBRIDEMENT OF SPECIMENS											040
041 SKIN BIOPSY						21.40*	21.40*	21.40*	25.00	27.20	041
042 CHEMOCAUTERY						42.60*	43.00	43.00	43.00	43.00	042
043 RADICAL MASTECTOMY						490.10*	598.90*	598.90*	748.70*	698.70*	043
044 OPEN REDUCTION OF FRACTURE						570.40*	684.50*	684.50*	798.60*	801.00	044
045 ARTHROCENTESIS-MAJOR JOINT						21.40*	25.70*	25.70*	24.20*	21.40*	045
046 ARTHROTOMY						21.40*	25.70*	25.70*	24.20*	21.40*	046
047 ARTHROPLASTY-REPAIR OF HIP	14.30*	17.10*	20.00	14.30*	14.30*	713.00*	855.60*	855.60*	798.60*	998.20*	047
048 NEEDLE PUNCTURE OF BURSA						14.30*	17.10*	14.30*	18.00	22.80*	048
049 BRONCHOSCOPY						107.00*	128.30*	128.30*	199.60*	150.00	049
050 THORACENTESIS						35.70*	35.70*	21.40*	35.70*	50.00	050

1979 PREVAILING CHARGE SUMMARY DATA WISCONSIN PHYSICIANS SERVICE

WISCONSIN

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

	B-12	C-13	D-14	K-15	E-19	B-12	C-13	D-14	K-15	E-19
051 CATHETERIZATION OF HEART						320.90*	385.00*	385.00*	449.20*	449.20*
052 INSERTION OF PACEMAKER						713.00*	850.00	850.00	850.00	850.00
053 PARTIAL COLECTOMY						570.40*	684.50*	684.50*	798.60*	753.40
054 APPENDECTOMY						208.60*	342.20*	256.70*	367.00	367.00
055 SIGMOIDOSCOPY	25.50	28.50*	21.40*	25.70*	25.70*	27.00	35.00	28.50*	28.50*	35.70*
056 HEMORRHOIDECTOMY						213.90*	213.90*	300.00	315.00	315.00
057 CHOLECYSTECTOMY						406.40*	513.40*	513.40*	641.70*	583.90
058 REPAIR HERNIA						285.20*	315.00	285.20*	356.50*	349.40*
059 DIAGNOSTIC CYSTOURETHROSCOPY	35.70*	42.80*	42.80*	45.00	47.10	35.70*	42.80*	42.80*	42.80*	47.10
060 DILATION OF URETHRA						13.00	13.00	13.00	12.80*	15.00
061 PROSTATECTOMY						570.40*	684.50*	684.50*	684.50*	798.60*
062 ELECTROSECTION-PROSTATE (TUR)	334.50*	320.90*	684.50*	782.00	753.40	570.40*	684.50*	684.50*	684.50*	753.40
063 HYSTERECTOMY						499.10*	598.90*	593.90	698.70*	748.70*
064 INITIAL COMPLETE EYE EXAM						15.00	21.00	16.80	26.00	17.10*
065 COMPREHENSIVE EYE EXAM						18.00	24.00	19.20	21.60	28.50*
066 EYE EXAM WITH TONOMETRY						12.00	11.50*	12.00	15.00	14.30*
067 EXTRACTION OF LENS	370.40*	684.50*	684.50*	700.00	700.00	600.00	641.70*	684.50	641.70*	684.50*
068 CHEST X-RAY, SINGLE VIEW	14.30*	17.10*	14.00	17.10*	17.00	17.10*	17.10*	14.30*	14.30*	14.30*
069 CHEST X-RAY, TWO VIEWS	25.00*	25.00	21.40*	25.70*	20.70	25.70*	25.70*	25.70*	25.80	22.10*
070 X-RAY SPINE						25.70*	25.70*	25.70*	35.00	31.40*
071 X-RAY HIP						34.20*	34.20*	34.20*	25.70*	21.40*
072 X-RAY UPPER GI TRACT	49.90*	35.70*	28.50*	42.80*	54.00	55.00	55.00	55.00	57.00*	44.20*
073 X-RAY COLON						55.00	55.00	55.00	57.00*	44.20*
074 RADIATION THERAPY-LOW VOLT	23.80*	24.90*	25.00	22.80*	25.00	20.00	20.00	20.00	20.00	20.00
075 RADIATION THERAPY-SUPER VOLT	35.00	35.00	35.00	35.00	35.00	35.00	35.00	35.00	35.00	35.00
076 RADIATION THERAPY-MEGAVOLT						38.00*	39.90*	35.70*	36.50*	40.00
077 CAT SCAN - HEAD						223.50*	234.20*	209.40*	214.40*	235.00
078 CAT SCAN-HEAD, INTERPRET ONLY						65.00	65.00	65.00	50.00	65.00
079 THREE CHEMISTRY TESTS						10.00	10.00	10.00	10.00	10.00
080 TWELVE CHEMISTRY TESTS						3.80	3.80	3.80	3.80	3.80
081 CULTURE-OTHER THAN BLOOD										
082 HEMOGLOBIN						4.00	4.00	4.00	4.00	4.00
083 AUTOMATED BLOOD COUNT						13.00	13.00	13.00	13.00	13.00
084 WHITE CELL COUNT						7.50	7.50	7.50	7.50	7.50
085 COMPLETE BLOOD COUNT (CBC)						6.50	6.50	6.50	6.50	6.50
086 CHOLESTEROL TEST						3.80	3.80	3.80	3.80	3.80
087 FLOCCULATION TEST						8.50	8.50	8.50	8.50	8.50
088 HEMATOCRIT						7.90	7.90	7.90	7.90	7.90
089 PLATELET COUNT (REES-ECKER)						6.40	6.40	6.40	6.40	6.40
090 POTASSIUM TEST						5.00	5.00	5.00	5.00	5.00
091 PROTHROMBIN						7.00	7.00	7.00	7.00	7.00
092 SEDIMENTATION RATE						8.00	8.00	8.00	8.00	8.00
093 BLOOD SUGAR						1.90	1.90	1.90	1.90	1.90
094 BUN-UREA-NITROGEN						8.00	8.00	8.00	8.00	8.00
095 URIC ACID						5.10	5.10	5.10	5.10	5.10
096 FECES-OCULT BLOOD						2.50	2.50	2.50	2.50	2.50
097 PAP TEST						20.00	20.00	20.00	20.00	20.00
098 ROUTINE URINALYSIS										
099 CHEMICAL URINALYSIS										
100 PATHOLOGY-THREE SPECIMENS										

1979 PREVAILING CHARGE SUMMARY DATA

WISCONSIN PHYSICIANS SERVICE

WISCONSIN

LOCALITY DESIGNATION FOR GENERAL PRACTICE LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

F-36

G-40

H-46

I-54

J-60

F-36

G-40

H-46

I-54

J-60

001 INITIAL BRIEF OFFICE VISIT
 002 INITIAL LIMITED OFFICE VISIT
 003 INIT INTERMED OFFICE VISIT
 004 INIT COMP OFFICE VISIT
 005 MINIMAL F/U OFFICE VISIT
 006 BRIEF F/U OFFICE VISIT
 007 LIMITED F/U OFFICE VISIT
 008 INTERMED F/U OFFICE VISIT
 009 EXTENDED F/U OFFICE VISIT
 010 COMPLETE F/U OFFICE VISIT
 011 BRIEF F/U HOME VISIT
 012 LIMITED F/U HOME VISIT
 013 INTERMEDIATE F/U HOME VISIT
 014 EXTENDED CARE FACILITY VISIT
 015 BRIEF F/U NURSING HOME VISIT
 016 INITIAL BRIEF HOSPITAL VISIT
 017 INIT INTERMED HOSPITAL VISIT
 018 INITIAL COMP HOSPITAL VISIT
 019 BRIEF F/U HOSPITAL VISIT
 020 LIMITED F/U HOSPITAL VISIT
 021 INTERMED F/U HOSPITAL VISIT
 022 EXTENDED F/U HOSPITAL VISIT
 023 BRIEF EMERGENCY ROOM VISIT
 024 LIMITED EMERGENCY ROOM VISIT
 025 INTERMED EMERGENCY ROOM VISIT
 026 LIMITED CONSULTATION
 027 EXTENSIVE CONSULTATION
 028 COMPREHENSIVE CONSULTATION
 029 PSYCHOTHERAPY-ONE HOUR
 030 PSYCHOTHERAPY-HALF HOUR
 031 CHIROPRACTIC OFFICE VISIT
 032 INITIAL PHYSIOTHERAPY
 033 F/U PODIATRIC OFFICE VISIT
 034 ELECTROCARDIOGRAM (EKG)
 035 EKG-INTERPRET, REPORT ONLY
 036 ARTERIAL BLOOD GAS STUDY
 037 ELECTROENCEPHALOGRAM (EEG)
 038 CHEMOTHERAPY
 039 COLLECTION OF SPECIMENS
 040 DEBRIDEMENT OF NAILS
 041 SKIN BIOPSY
 042 CHEMOCAUTERY
 043 RADICAL MASTECTOMY
 044 OPEN REDUCTION OF FRACTURE
 045 ARTHROCENTESIS-MAJOR JOINT
 046 ARTHROTOMY
 047 ARTHROPLASTY-REPAIR OF HIP
 048 NEEDLE PUNCTURE OF BURSA
 049 BRONCHOSCOPY
 050 THORACENTESIS

23.00 25.70* 28.50* 23.00 23.00 10.50 20.00 20.00 17.00 15.00 001
 30.00 35.00 30.00 23.50* 29.70* 34.20 35.00 40.00 32.00 37.50 002
 4.30* 4.30* 5.00 4.30* 4.30* 42.80* 42.80* 40.00 32.00 37.50 003
 8.60* 7.10* 10.00 8.60* 8.60* 7.10* 4.30* 5.70* 5.00 5.50 004
 11.40* 10.00 12.00 11.40* 12.80* 14.30* 8.60* 11.40* 10.00 10.00 005
 14.30* 14.30* 13.00 17.10* 17.10* 14.30* 12.00 14.30* 12.00 12.00 006
 25.00 25.00 22.80* 25.00 21.40* 28.50* 21.40* 25.00 25.00 28.50* 007
 28.50* 25.70* 28.50* 28.50* 35.70* 35.70* 28.50* 35.70* 35.70* 45.00 008
 14.30* 14.30* 17.10* 14.30* 14.30* 14.30* 14.30* 17.10* 14.30* 14.30* 009
 15.00 21.40* 24.00 24.00 21.40* 14.30* 16.00 22.00 22.00 21.40* 010
 10.00 8.60 14.30* 10.00 12.00 10.00 8.60* 14.30* 14.30* 12.00 011
 25.70* 28.50* 34.20* 28.50* 28.50* 35.00 42.80* 49.90* 42.80* 49.90* 012
 40.00 40.00 64.20* 52.00 52.00 51.30* 49.90* 56.00 42.80* 49.90* 013
 8.60* 8.60* 10.00* 10.00* 8.60* 11.40* 11.40* 14.30* 14.30* 11.40* 014
 12.00 8.00 14.30* 14.30* 14.30* 17.10* 14.00 14.30* 14.30* 13.00 015
 12.00 8.00 14.30* 14.30* 14.30* 17.10* 14.00 14.30* 14.30* 13.00 016
 20.00 20.00 20.00 15.00 20.00 21.40* 25.00 28.50* 20.00 20.00 017
 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 018
 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 019
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 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 036
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 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 038
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 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 040
 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 041
 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 042
 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 043
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 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 048
 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 049
 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 050

1979 PREVAILING CHARGE SUMMARY DATA WISCONSIN PHYSICIANS SERVICE

WISCONSIN

LOCALITY DESIGNATION FOR GENERAL PRACTICE

LOCALITY DESIGNATION FOR SPECIALIST

PROCEDURE DESCRIPTION

F-36 G-40 H-46 I-54 J-60

F-36 G-40 H-46 I-54 J-60

051 CATHETERIZATION OF HEART	385.00*	356.50*	417.10*	385.00*	385.00*	051
052 INSERTION OF PACEMAKER	850.00	850.00	850.00	850.00	850.00	052
053 PARTIAL COLECTOMY	684.50*	684.50*	741.50*	684.50*	684.50*	053
054 APPENDECTOMY	342.20*	342.20*	356.50*	367.00	363.60*	054
055 SIGMOIDOSCOPY	25.70*	30.00	35.70*	28.50*	35.70*	055
056 HEMORRHOIDECTOMY	285.00	256.70*	285.20*	279.50*	256.70*	056
057 CHOLECYSTECTOMY	513.40*	513.40*	556.10*	579.00*	534.75*	057
058 REPAIR HERNIA	299.50*	299.50*	342.20*	356.50*	299.50*	058
059 DIAGNOSTIC CYSTOURETHROSCOPY	42.80*	42.80*	46.40*	42.80*	42.80*	059
060 DILATION OF URETHRA	17.10*	12.00	13.00	13.00	12.00	060
061 PROSTATECTOMY	684.50*	684.50*	770.00*	574.00	684.50	061
062 ELECTROSECTION-PROSTATE (TUR)	684.50*	684.50*	741.50*	684.50*	684.50	062
063 HYSTERECTOMY	641.70*	598.90*	641.70*	718.70*	641.70*	063
064 INITIAL COMPLETE EYE EXAM	19.00	20.00	17.00	27.00	19.00	064
065 COMPREHENSIVE EYE EXAM	25.10*	24.00	22.80*	23.20	19.20	065
066 EYE EXAM WITH TONOMETRY	17.10*	14.30*	14.00	12.00	11.40*	066
067 EXTRACTION OF LENS	684.50*	684.50*	713.00*	627.40*	570.40*	067
068 CHEST X-RAY, SINGLE VIEW	15.00	17.10*	16.00	17.10*	14.30*	068
069 CHEST X-RAY, TWO VIEWS	23.00	25.00	25.70*	21.40*	21.40*	069
070 X-RAY SPINE	49.90*	51.30*	51.30*	28.50*	21.40*	070
071 X-RAY HIP	49.90*	51.30*	51.30*	28.50*	34.20*	071
072 X-RAY UPPER GI TRACT	49.90*	51.30*	51.30*	28.50*	34.20*	072
073 X-RAY COLON	49.90*	51.30*	51.30*	28.50*	34.20*	073
074 RADIATION THERAPY-LOW VOLT	25.00	20.60*	23.70*	42.80*	49.90*	074
075 RADIATION THERAPY-SUPER VOLT	35.00	35.00	35.00	42.80*	49.90*	075
076 RADIATION THERAPY-MEGAVOLT	35.00	35.00	35.00	42.80*	49.90*	076
077 CAT SCAN - HEAD	235.00	193.60*	223.10*	224.20*	231.30*	077
078 CAT SCAN-HEAD, INTERPRET ONLY	85.00	65.00	65.00	65.00	65.00	078
079 THREE CHEMISTRY TESTS	10.00	10.00	10.00	10.00	10.00	079
080 TWELVE CHEMISTRY TESTS	3.80	3.80	3.80	3.80	3.80	080
081 CULTURE-OTHER THAN BLOOD	4.00	4.00	4.00	4.00	4.00	081
082 HEMOGLOBIN	13.00	13.00	13.00	13.00	13.00	082
083 AUTOMATED BLOOD COUNT	7.50	7.50	7.50	7.50	7.50	083
084 WHITE CELL COUNT	6.50	6.50	6.50	6.50	6.50	084
085 COMPLETE BLOOD COUNT (CBC)	3.80	3.80	3.80	3.80	3.80	085
086 CHOLESTEROL TEST	8.50	8.50	8.50	8.50	8.50	086
087 FLOCCULATION TEST	7.90	7.90	7.90	7.90	7.90	087
088 HEMATOCRIT	6.40	6.40	6.40	6.40	6.40	088
089 PLATELET COUNT (REES-ECKER)	5.00	5.00	5.00	5.00	5.00	089
090 POTASSIUM TEST	7.00	7.00	7.00	7.00	7.00	090
091 PROTHROMBIN	8.00	8.00	8.00	8.00	8.00	091
092 SEDIMENTATION RATE	1.90	1.90	1.90	1.90	1.90	092
093 BLOOD SUGAR	8.00	8.00	8.00	8.00	8.00	093
094 BUN-URCA,NITROGEN	5.10	5.10	5.10	5.10	5.10	094
095 URIC ACID	2.55	2.50	2.50	2.50	2.50	095
096 FECES-OCCULT BLOOD	20.00	20.00	20.00	20.00	20.00	096
097 PAP TEST						097
098 ROUTINE URINALYSIS						098
099 CHEMICAL URINALYSIS						099
100 PATHOLOGY-THREE SPECIMENS						100

WYOMING

WYOMING



PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	SINGLE		SINGLE	
001 INITIAL BRIEF OFFICE VISIT			20.00	001
002 INITIAL LIMITED OFFICE VISIT	28.50		42.80	002
003 INIT INTERMED OFFICE VISIT			42.80	003
004 INIT COMP OFFICE VISIT	57.00		49.90	004
005 MINIMAL F/U OFFICE VISIT	6.00		5.70	005
006 BRIEF F/U OFFICE VISIT	8.60		10.00	006
007 LIMITED F/U OFFICE VISIT	11.40		14.30	007
008 INTERMED F/U OFFICE VISIT	15.70		21.40	008
009 EXTENDED F/U OFFICE VISIT	25.00		28.50	009
010 COMPLETE F/U OFFICE VISIT	35.00		42.80	010
011 BRIEF F/U HOME VISIT	14.30		17.10	011
012 LIMITED F/U HOME VISIT			21.00	012
013 INTERMEDIATE F/U HOME VISIT	20.00		37.80	013
014 EXTENDED CARE FACILITY VISIT			21.60	014
015 BRIEF F/U NURSING HOME VISIT	8.60		10.80	015
016 INITIAL BRIEF HOSPITAL VISIT	21.40		35.60	016
017 INIT INTERMED HOSPITAL VISIT			49.90	017
018 INITIAL COMP HOSPITAL VISIT	46.30		57.00	018
019 BRIEF F/U HOSPITAL VISIT	11.40		14.30	019
020 LIMITED F/U HOSPITAL VISIT	15.00		14.30	020
021 INTERMED F/U HOSPITAL VISIT	25.90		26.25	021
022 EXTENDED F/U HOSPITAL VISIT			21.40	022
023 BRIEF EMERGENCY ROOM VISIT			17.90	023
024 LIMITED EMERGENCY ROOM VISIT			41.04	024
025 INTERMED EMERGENCY ROOM VISIT			23.70	025
026 LIMITED CONSULTATION	28.50		26.80	026
027 EXTENSIVE CONSULTATION			43.00	027
028 COMPREHENSIVE CONSULTATION			80.00	028
029 PSYCHOTHERAPY-ONE HOUR			40.00	029
030 PSYCHOTHERAPY-HALF HOUR			30.00	030
031 CHIROPRACTIC OFFICE VISIT	8.30		8.60	031
032 INITIAL PHYSIOTHERAPY				032
033 F/U PODIATRIC OFFICE VISIT			10.00	033
034 ELECTROCARDIOGRAM (EKG)	21.40		21.40	034
035 EKG-INTERPRET, REPORT ONLY	7.50		7.50	035
036 ARTERIAL BLOOD GAS STUDY			75.60	036
037 ELECTROENCEPHALOGRAPH (EEG)			60.10	037
038 CHEMOTHERAPY				038
039 COLLECTION OF SPECIMENS			3.00	039
040 DEBRIDEMENT OF NAILS			10.00	040
041 SKIN BIOPSY			21.40	041
042 CHEMOCAUTERY			14.00	042
043 RADICAL MASTECTOMY			570.60	043
044 OPEN REDUCTION OF FRACTURE			570.60	044
045 ARTHROCENTESIS-MAJOR JOINT			28.50	045
046 ARTHROTOMY			21.40	046
047 ARTHROPLASTY-REPAIR OF HIP	19.20		900.00	047
048 NEEDLE PUNCTURE OF BURSA			21.40	048
049 BRONCHOSCOPY			117.00	049
050 THORACENTESIS			21.40	050

1979 PREVAILING CHARGE SUMMARY DATA

EQUITABLE LIFE ASSURANCE SOCIETY

WYOMING

PROCEDURE DESCRIPTION	LOCALITY DESIGNATION FOR GENERAL PRACTICE		LOCALITY DESIGNATION FOR SPECIALIST	
	SINGLE		SINGLE	

051	CATHERIZATION OF HEART		364.50	051
052	INSERTION OF PACEMAKER		810.00	052
053	PARTIAL COLECTOMY		630.00	053
054	APPENDECTOMY		320.90	054
055	SIGMOIDOSCOPY	21.10	21.40	055
056	HEMORRHOIDECTOMY		235.40	056
057	CHOLECYSTECTOMY		535.00	057
058	REPAIR HERNIA		285.30	058
059	DIAGNOSTIC CYSTOURETHROSCOPY	32.00	42.80	059
060	DILATION OF URETHRA		14.30	060
061	PROSTATECTOMY	537.50	648.00	061
062	ELECTROSECTION-PROSTATE (TUR)		570.60	062
063	HYSTERECTOMY		641.90	063
064	INITIAL COMPLETE EYE EXAM		21.50	064
065	COMPREHENSIVE EYE EXAM		21.50	065
066	EYE EXAM WITH TONOMETRY		10.30	066
067	EXTRACTION OF LENS	512.00	599.10	067
068	CHEST X-RAY, SINGLE VIEW	14.30	16.80	068
069	CHEST X-RAY, TWO VIEWS	21.40	21.40	069
070	X-RAY SPINE		21.40	070
071	X-RAY HIP		21.40	071
072	X-RAY UPPER GI TRACT	42.60	42.80	072
073	X-RAY COLON		42.80	073
074	RADIATION THERAPY-LOW VOLT	22.20	9.10	074
075	RADIATION THERAPY-SUPER VOLT	29.60	17.80	075
076	RADIATION THERAPY-MEGAVOLT			076
077	CAT SCAN - HEAD		288.00	077
078	CAT SCAN-HEAD, INTERPRET ONLY		288.00	078
079	THREE CHEMISTRY TESTS			079
080	TWELVE CHEMISTRY TESTS			080
081	CULTURE-OTHER THAN BLOOD			081
082	HEMOGLOBIN		10.00	082
083	AUTOMATED BLOOD COUNT		3.00	083
084	WHITE CELL COUNT		10.70	084
085	COMPLETE BLOOD COUNT (CBC)		3.75	085
086	CHOLESTEROL TEST		10.70	086
087	FLOCCULATION TEST		11.00	087
088	HEMATOCRIT		5.00	088
089	PLATELET COUNT (REES-ECKER)		3.60	089
090	POTASSIUM TEST		6.00	090
091	PROTHROMBIN		10.10	091
092	SEDIMENTATION RATE		7.00	092
093	BLOOD SUGAR		5.70	093
094	BUN-UREA-NITROGEN		10.00	094
095	URIC ACID		11.00	095
096	FECES-OCCULT BLOOD		10.00	096
097	PAP TEST		3.00	097
098	ROUTINE URINALYSIS		11.00	098
099	CHEMICAL URINALYSIS		2.79	099
100	PATHOLOGY-THREE SPECIMENS		2.73	100

FSY 1979
PREVAILING CHARGE SCREENS
FOR
SELECTED DURABLE MEDICAL EQUIPMENT

FINANCING ADMINISTRATION REGIONS WITH THE MEDICARE PART B CARRIERS NOTED



FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION I
(Boston)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Maine	Massachusetts	N. Hampshire	Vermont	Rhode Island	Connecticut
Massachusetts BS	N.H./Vt. Phys. Serv.	R.I. BS	Connecticut General		
Statewide	Urban	Suburban	Statewide	Statewide	I II III IV

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 43.00 55.00 \$ 60.00 no data no data \$ 18.00 \$ 57.25 \$ 64.20 \$ 63.10 \$ 63.10

Walker--Standard, open
end, nonfolding

no data 15.00 7.50 \$ 6.00 \$ 7.50 4.00 10.70 12.00 10.70 15.00

Wheelchair--Standard,
adult

20.00 30.00 20.00 20.00 27.40 10.00 20.00 35.00 25.00 33.00

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual
with mattress

no data no data no data no data no data 484.00 535.00 535.00 535.00 535.00

Walker--Standard, open
end, nonfolding

no data 26.90 30.00 23.30 27.40 24.90 32.10 26.50 32.10 35.30

Wheelchair--Standard,
adult

239.00 300.00 271.00 205.70 no data 210.00 276.00 256.00 256.00 256.00

^{1/} Monthly payments

DURABLE MEDICAL EQUIPMENT

REGION II
(New York)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

New York				N. Jersey		Puerto Rico	
BS of Greater New York		GHI	Metropolitan	GVMC	BS of WNY	Prudential	SSS
A	B	Queens	Carrierwide	Carrierwide	Carrierwide	Statewide	Islandwide
C							

1/
RENTAL EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

Walker--Standard, open
end, nonfolding

Wheelchair--Standard,
adult

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

Walker--Standard, open
end, nonfolding

Wheelchair--Standard,
adult

1/ Monthly payments

\$ 45.00	\$ 45.00	\$ 45.00	\$ 45.00	\$ 40.00	\$ 35.00	\$ 26.75	\$ 55.00	\$ 30.00
10.00	10.00	10.00	8.50	8.00	8.50	8.00	10.00	No data
30.00	25.00	30.00	21.60	20.00	20.00	17.70	25.00	20.00
325.00	325.00	325.00	374.50	495.00	494.50	214.00	50.00	340.00
55.00	55.00	55.00	110.10	28.50	31.00	36.40	30.00	35.00
200.00	225.00	225.00	192.60	222.00	276.00	191.60	25.00	185.00

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION III
(Philadelphia)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Pennsylvania					West Virginia	
Pennsylvania Blue Shield					Nationwide	
1	2	3	4		Locality 16	Localities 17-20

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 50.00 \$ 49.00 \$ 45.00 \$ 55.00 \$ 43.00 \$ 42.20

Walker--Standard, open
end, nonfolding

17.00 12.00 14.00 10.00 6.00 12.02

Wheelchair--Standard,
adult

30.00 26.50 27.00 27.00 18.54 20.00

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

450.00 450.00 450.00 450.00 425.00 425.00

Walker--Standard, open
end, nonfolding

35.00 30.00 32.00 24.00 39.14 32.85

Wheelchair--Standard,
adult

180.00 225.00 188.00 229.00 228.66 228.66

/ Monthly payments

DURABLE MEDICAL EQUIPMENT

REGION III

(Cont'd)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Maryland			Delaware	District of Columbia	Virginia
Maryland Blue Shield			Delaware BS	Medical Service D.C.	Travelers
Zone 1	Zone 2	Zone 3	Statewide	Washington	Statewide

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard, fixed height, manual, with mattress

\$ 49.00 \$ 40.00 \$ 59.50 \$ 45.00 \$ 49.00 \$ 49.00

Walker--Standard, open end, nonfolding

10.75 6.00 8.50 8.50 11.50 11.50

Wheelchair--Standard, adult

25.00 16.00 25.00 30.00 24.50 15.00

PURCHASED EQUIPMENT

Hospital Bed--Standard, fixed height, manual, with mattress

320.00 320.00 320.00 525.00 387.00 394.00

Walker--Standard, open end, nonfolding

30.00 30.00 30.00 35.00 36.00 30.00

Wheelchair--Standard, adult

220.00 220.00 220.00 220.00 281.00 187.00

1/ Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION IV
(Atlanta)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Kentucky	Tennessee	N. Carolina	S. Carolina	Georgia
Metropolitan	Equitable	Prudential	S. Carolina BS	Prudential
Statewide	Statewide	Statewide	Statewide	Statewide

RENTAL EQUIPMENT 1/

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 36.60 \$ 40.80 \$ 32.00 \$ 36.40 \$ 39.50

Walker--Standard, open
end, nonfolding

6.00 7.31 6.00 8.32 7.28

Wheelchair--Standard,
adult

19.40 21.00 17.25 22.88 18.20

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

387.90 395.00 339.00 395.00 309.00

Walker--Standard, open
end, nonfolding

31.45 32.04 29.95 31.20 34.90

Wheelchair--Standard,
adult

215.00 209.95 195.00 225.00 188.20

1/ Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION IV
(Cont'd)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Alabama	Mississippi	Florida
Alabama BS	Travelers	Florida BS
Statewide	Statewide	Localities A-C
		Dade/Monroe Counties

RENTAL EQUIPMENT ^{1/}

Hospital Bed--Standard, fixed height, manual, with mattress

\$ 38.80 \$ 42.00 \$ 46.80 \$ 46.80

Walker--Standard, open end, nonfolding

8.00 10.50 7.00 7.00

Wheelchair--Standard, adult

25.00 21.00 23.00 23.00

PURCHASED EQUIPMENT

Hospital Bed--Standard, fixed height, manual, with mattress

350.00 420.00 395.00 395.00

Walker--Standard, open end, nonfolding

33.50 31.50 30.00 30.00

Wheelchair--Standard, adult

327.50 207.90 215.00 215.00

1/ Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION V
(Chicago)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Michigan			Indiana			Ohio		
Michigan Blue Shield			Indiana Blue Shield			Nationwide		
1	2	3	01	02	03	01	02	03 04 05

RENTAL EQUIPMENT ^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 55.00 \$ 35.00 \$ 42.00 \$ 49.50 \$ 45.00 \$ 50.00 \$ 30.00 \$ 50.00 \$ 42.20 \$ 30.16 \$ 36.58

Walker--Standard, open
end, nonfolding

13.00 7.80 5.00 8.00 12.00 12.00 6.50 13.00 12.13 6.24 7.32

Wheelchair--Standard,
adult

25.00 18.00 20.00 24.00 24.50 30.00 16.00 30.00 20.00 15.00 16.00

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

no data no data no data 402.50 460.00 426.30 360.89 425.00 425.00 425.00 425.00

Walker--Standard, open
end, nonfolding

25.00 24.50 39.50 36.40 34.50 33.00 30.35 35.00 30.55 27.19 32.85

Wheelchair--Standard,
adult

208.00 228.80 207.00 219.90 228.00 221.00 200.00 249.00 224.80 221.00 228.66

^{1/} Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION V
(Cont'd)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Ohio (Cont'd)			Illinois									
Nationwide			Continental Casualty (CNA)									
06-10, 12-14	11	15	01, 06, 08, 10, 11	02	03	04	05	07	09			

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard, fixed height, manual, with mattress

\$ 42.20 \$ 51.21 \$ 40.00 \$ 50.00 \$ 38.00 \$ 50.00 \$ 51.00 \$ 50.00 \$ 50.00 \$ 50.00 \$ 40.00

Walker--Standard, open end, nonfolding

12.02 12.02 6.00 11.00 11.00 11.00 11.00 7.50 11.00 11.00

Wheelchair--Standard, adult

20.00 30.00 15.00 20.00 25.00 31.50 20.00 17.50 19.75 15.00

PURCHASED EQUIPMENT

Hospital Bed--Standard, fixed height, manual, with mattress

425.00 425.00 425.00 327.10 327.10 327.10 327.10 327.10 327.10 327.10

Walker--Standard, open end, nonfolding

32.85 38.90 32.85 40.00 42.00 40.00 43.10 36.00 40.00 42.50

Wheelchair--Standard, adult

228.66 228.66 228.66 204.75 187.50 204.75 204.75 205.80 195.30 204.75

^{1/} Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

APPENDIX B

DURABLE MEDICAL EQUIPMENT

REGION V

(Cont'd)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Illinois (Cont'd)				Wisconsin			Minnesota	
Illinois (Cont'd)		Illinois BS		Wisc. Phy. Ser.		Surgical Care	Travelers	Minnesota BS
12	13	14	15	Cook County		All localities	Milwaukee	Area 1

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

Walker--Standard, open
end, nonfolding

Wheelchair--Standard,
adult

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

Walker--Standard, open
end, nonfolding

Wheelchair--Standard,
adult

1/ Monthly payments

38.00 37.50 35.00 50.00 50.00 39.00 42.00 47.00 45.30

9.00 11.00 11.00 12.00 15.00 7.50 12.00 11.50 10.50

20.00 15.00 20.00 22.00 24.50 19.00 24.00 21.50 20.00

327.10 327.10 327.10 327.10 395.00 400.00 397.00 378.00 369.50

34.40 40.00 40.00 40.00 34.80 34.40 33.00 32.00 29.95

204.00 204.75 204.75 116.00 325.00 229.00 235.00 276.00 225.00

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION VI
(Dallas)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

New Mexico	Texas	Oklahoma					DISRS	
Equitable	Texas BS	Aetna						
Statewide	Statewide	01	02	03	04	05	All localities	

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

Walker--Standard, open
end, nonfolding

Wheelchair--Standard
adult

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

Walker--Standard, open
end, nonfolding

Wheelchair--Standard,
adult

1/ Monthly payments

\$ 33.00	\$ 38.00	\$ 35.00	\$ 43.00	\$ 41.60	\$ 36.40	\$ 36.40	same
6.26	12.50	8.32	8.32	8.32	8.32	8.32	as
18.72	25.00	19.76	19.76	18.20	19.76	21.89	Oklahoma, Aetna
338.00	478.00	477.30	244.40	477.30	477.30	535.50	same
37.53	50.00	28.50	28.50	28.50	28.50	28.50	as
226.69	209.00	205.00	189.90	208.10	210.10	200.80	Oklahoma, Aetna

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION VI
(Cont'd)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

	Louisiana						
	Pan American Life Insurance						
	01	02	03	04	05,07	06	08
Arkansas							
Arkansas BS							
Statewide							

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 41.20 \$ 36.10 \$ 36.10 \$ 29.70 \$ 36.75 \$ 36.10 \$ 36.10 \$ 31.50

Walker--Standard, open
end, nonfolding

10.30 11.70 9.50 8.50 9.50 9.50 10.50 9.50

Wheelchair--Standard,
adult

25.75 25.20 21.20 21.20 19.40 21.20 21.00 18.90

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

432.00 338.00 338.00 338.00 338.00 338.00 338.00 338.00

Walker--Standard, open
end, nonfolding

47.90 32.80 44.70 31.40 38.40 36.00 42.00 30.30

Wheelchair--Standard,
adult

194.00 182.30 208.00 208.00 178.50 208.00 208.00 174.10

1/ Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION VII

(Kansas City)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Kansas		Missouri					
Kansas BS	BS of Kansas City	BS of Kansas City			General American Life		
01	04	05	01	02	03	06	1 2 3

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard, fixed height, manual, with mattress

\$ 35.00 \$ 40.00 \$ 50.15 \$ 50.15 \$ 50.15 \$ 52.50 \$ 31.24 \$ 43.50 \$ 32.00 \$ 35.00

Walker--Standard, open end, nonfolding

8.00 12.27 12.27 12.27 12.27 12.27 6.00 12.00 8.00 9.00

Wheelchair--Standard, adult

18.00 18.11 22.25 20.63 15.00 25.50 25.00 23.00 20.00 19.00

PURCHASED EQUIPMENT

Hospital Bed--Standard, fixed height, manual with mattress

545.81 358.82 358.82 358.82 358.82 364.00 358.82 312.00 312.00 312.00

Walker--Standard, open end, nonfolding

35.00 37.96 37.96 37.96 37.96 35.77 44.86 34.50 43.00 37.00

Wheelchair--Standard, adult

221.00 216.58 216.58 216.58 216.58 221.00 208.00 191.00 191.00 191.00

1/ Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION VII
(Cont'd)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Nebraska		Iowa						
Mutual of Omaha		Blue Shield of Iowa						
Areas 1, 3	Area 4	01	02	03, 08	04	05	06	07

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 36.40 \$ 36.40 \$ 30.00 \$ 30.00 \$ 30.00 \$ 30.00 \$ 12.00 \$ 30.00 \$ 30.00

Walker--Standard, open
end, nonfolding

5.00 7.00 5.00 3.50 5.00 3.00 5.00 5.00 5.00

Wheelchair--Standard,
adult

16.80 9.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

312.00 312.00 451.00 451.00 451.00 451.00 451.00 451.00 451.00

Walker--Standard, open
end, nonfolding

34.40 35.00 42.00 34.00 34.50 34.50 34.50 37.00 33.00

Wheelchair--Standard,
adult

242.00 242.00 276.00 276.00 276.00 276.00 276.00 276.00 276.00

^{1/} Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION VIII
(Denver)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Colorado	Utah	Wyoming	South Dakota	North Dakota	Montana
Colorado BS	Utah BS	Equitable	S. Dakota Med. Serv.	BS of N. Dakota	Mt. Phys. Serv.
Statewide	Statewide	Statewide	Statewide	Statewide	Statewide

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 37.50 \$ 39.40 \$ 32.50 \$ 26.25 \$ 50.00 \$ 75.00

Walker--Standard, open
end, nonfolding

12.00 13.10 3.00 8.40 5.00 12.50

Wheelchair--Standard,
adult

23.00 22.10 18.50 19.80 20.00 30.00

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

549.60 450.00 325.00 no data 536.40 590.00

Walker--Standard, open
end, nonfolding

35.70 44.00 30.00 36.75 41.00 41.00

Wheelchair--Standard,
adult

276.90 270.00 185.00 no data no data 433.00

1/ Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION IX

(San Francisco)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

California

California Physicians Service					Occidental Life		
01,02,04	03,05-07,09	08,10-14	15,27	16,17	18-26,28	15,27	18-25

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard, fixed height, manual, with mattress

\$ 48.50 \$ 51.00 \$ 47.20 \$ 44.00 \$ 37.10 \$ 49.50 \$ 44.00 \$ 37.10 \$ 49.50 \$ 49.50

Walker--Standard, open end, nonfolding

10.10 26.00 25.40 20.00 19.60 22.00 11.70 13.25 14.50 13.50

Wheelchair--Standard, adult

27.50 28.00 27.00 22.00 22.80 28.50 22.00 22.80 28.50 29.50

PURCHASED EQUIPMENT

Hospital Bed--Standard, fixed height, manual, with mattress

468.00 468.00 388.20 430.40 465.30 465.30 430.40 465.30 465.30 465.30

Walker--Standard, open end, nonfolding

186.56 186.56 186.56 189.74 189.74 189.74 40.00 38.70 42.40 42.40

Wheelchair--Standard, adult

281.40 242.80 238.50 225.00 243.75 252.20 225.00 243.75 252.20 235.60

^{1/} Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION IX
(Cont'd)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

Nevada		Hawaii		Arizona			
Aetna		Aetna		Aetna			
01	02, 03, 99	Islandwide	01	02	05, 07	08	99

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 42.50 \$ 50.00 \$ 52.00 \$ 39.90 \$ 41.87 \$ 41.87 \$ 45.00 \$ 41.87

Walker--Standard, open
end, nonfolding

20.70 20.70 no data 9.54 8.93 8.93 10.50 no data

Wheelchair--Standard,
adult

25.90 25.90 31.20 23.63 22.26 23.32 26.25 23.32

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

231.75 231.75 572.00 450.50 450.50 no data no data 450.50

Walker--Standard, open
end, nonfolding

134.55 134.55 no data 39.90 36.40 39.85 34.35 39.85

Wheelchair--Standard,
adult

103.50 103.50 295.40 213.00 259.40 213.00 217.00 213.00

1/ Monthly payments

FSY 1979 PREVAILING CHARGE SUMMARY DATA

DURABLE MEDICAL EQUIPMENT

REGION X
(Seattle)

PREVAILING CHARGE SCREENS BY STATE/CARRIER/LOCALITY

	Washington				Oregon		Idaho	
	Washington Physicians Service		Aetna		Statewide		Equitable	
	01	02	03	04			South	North

RENTAL EQUIPMENT^{1/}

Hospital Bed--Standard,
fixed height, manual,
with mattress

\$ 61.60 \$ 42.04 \$ 57.97 \$ 42.04 \$ 42.04 \$ 44.00 \$ 40.70 \$ 40.70

Walker--Standard, open
end, nonfolding

11.20 10.51 12.65 14.71 10.51 8.00 7.20 7.20

Wheelchair--Standard,
adult

32.90 24.17 30.57 21.02 24.17 23.50 15.50 15.50

PURCHASED EQUIPMENT

Hospital Bed--Standard,
fixed height, manual,
with mattress

700.00 488.25 377.60 377.60 377.60 500.00 500.00 500.00

Walker--Standard, open
end, nonfolding

65.80 39.41 38.62 38.62 38.62 47.00 40.00 40.00

Wheelchair--Standard,
adult

337.40 247.69 211.85 236.48 228.32 241.00 247.00 265.00

1/ Monthly payments

APPENDIX A

ALABAMA

Six Localities:

- 01 Seven N.W. Counties: Calbert, Franklin, Lauderdale, Lawrence, Limestone, Madison, Morgan
- 02 Six North Central Counties: Calhoun, Dekalb, Etowah, Fayette, Marshall, Tuscaloosa
- 03 Eight S.E. Counties: Butler, Covington, Crenshaw, Dallas, Houston, Lee, Montgomery, Russell
- 04 Two S.W. Counties: Baldwin, Mobile (city)
- 05 One large Metropolitan County: Jefferson

06 Forty-one small Rural Counties:

Autauga	Henry
Barbour	Jackson
Bibb	Lamar
Blount	Lowades
Bullock	Marengo
Chambers	Marion
Cherokee	Monroe
Chilton	Perry
Clark	Pickens
Clay	Pike
Clebourne	Randolph
Coffee	St. Clair
Conceh	Shelby
Cocca	Sumter
Cullman	Talladega
Dale	Tallapoosa
Elmore	Walker
Escambia	Washington
Geneva	Wilcox
Greene	Winston
Hale	

ARIZONA

Six Localities:

- 01--Phoenix---including Avondale, Chandler, Clearwater Hills, Cashion, Desert Sage, El Mirage, Gilbert, Glendale, Goodyear, Guadalupe, Litchfield Park, Mesa, Paradise Valley, Peoria, Scottsdale, Sun City, Surprise, Tempe, Tolleson, and Youngtown.
 - 02--Tucson---including Casas Adobes, Catalina Foothills, Desert Steppes, Indiana Ridge Estates, Sherwood Village, South Tucson, and Vista Del Sahuaro.
 - 05--Flagstaff
 - 07--Prescott
 - 08--Yuma
 - 99--All other parts of the State
- (City limits are exact boundaries of localities)

CALIFORNIA

Twenty-eight Localities - Conform to PSNO Areas:

Blue Shield handles all of 1-14 and the Medicare/Medi-Cal claims from 15-28

Occidental handles non-Medi-Cal Claims from 15-28

There are 42 screens for California as a result of the overlap.

01 - Del Norte, Humboldt, Lake, Mendocino, Sonoma

02 - Butte, Colusa, Glenn, Lassen, Modoc, Plumas, Sierra, Shasta, Siskiyou, Sutter, Tehama, Trinity, Yuba

03 - Marin, Napa, Solano

04 - El Dorado, Nevada, Placer, Sacramento, Yolo

05 - San Francisco

06 - San Mateo

07 - Alameda & Contra Costa

08 - Alpine, Amador, Calaveras, San Joaquin & Tuolumne

09 - Santa Clara

10 - Mariposa, Merced, Stanislaus

11 - Madera, Fresno

12 - Monterey, San Benito, Santa Cruz

13 - Kings and Tulare

14 - Kern

15 - Inyo, Mono, San Bernardino

16 - San Luis, Obispo, Santa Barbara

17 - Ventura

(Localities 18 through 25 are composed of cities and parts of Los Angeles denoted by ZIP Codes)

18 :	Altadena Alhambra San Marino Tujunga Glendale San Gabriel Temple City Sunland	Verdugo City Pasadena Garvey Eagle Rock Rosemead La Crescenta Monterose	La Vina El Monte South Pasadena Monterey Park La Canada South San Gabriel Milmar
19 :	Avalon Wilmington Palos Verdes Estates Long Beach	Terminal Island Hawaiian Gardens Lakewood San Pedro	Dominquez Harbor City Palos Verdes Peninsula Los Alamitos
20 :	Agoura Palmdale Chatsworth Burbank Hidden Hills Olive View Rosedale San Fernando Tarzana Sun Valley Lancaster	Littlerock Canoga Park Quartz Hill Granada Hills North Hollywood Northridge Panorama City Sherman Oaks Studio City Woodland Hills Toluca Lake	Calabasas Pearblossom Encino Mission Hills Hewhall Pacoima Saugus Sepulveda Van Nuys Sylmar
21 :	Commerce Glendora East Los Angeles Rowland Heights Norwalk Valinda Whittier La Verne Baldwin Park Walnut	Durante La Mirada Monrovia Montebello Santa Fe Springs Claremont Azusa San Dimas	Hacienda Heights La Puente Los Nietos Sierra Madre Pico Rivera West Covina Arcadia Pomona Covina

22 :	Culver City	Santa Monica	Malibu	25 :	Beverly Hills	90029
	Sawtelle	Marina del Rey	Venice		Los Angeles Postal Zones:	90046
	Mar Vista	Westwood	Ocean Park		90027	90068
	Pacific Palisades	Palms	Playa del Rey		90036	
	Los Angeles Postal Zones:				90048	
	90034	90049	90064			
	90066	90073		26 :	Orange County	
23 :	Gardena	Rolling Hills	Hermosa Beach			
	Torrance	Lomita	Artesia	27 :	Riverside County	
	Manhattan Beach	Bell	Palos Verdes			
	Bellflower	Redondo Beach	Bell Gardens			
	Compton	Willowbrook	Downey	28 :	San Diego & Imperial Counties.	
	El Segundo	Home Gardens	Hawthorne			
	Huntington Park	Inglewood	Lynwood			
	Lawndale	Maywood	Lennox			
	Paramount	South Gate				
	Los Angeles Postal Zones:					
	90009	90045				
24 :	Los Angeles Postal Zones:	Metropolitan Center				
	90006	90013	90033			
	90008	90056	90007			
	90012	90023	90053			
	90043	90062	90018			
	90058	90005	90014			
	90035	90042	90059			
	90002	90016	90031			
	90003	90055	90004			
	90057	90020	90039			
	90037	90001	90010			
	90017	90065	90054			
	90047	90026	90019			
	90021	90011	90063			
	90061	90015	90051			
	90032	90044				

CONNECTICUT

Four Localities:

- 01- Northwest and North Central - City of New London, Hartford County, Litchfield County (except New Milford, Washington, Bridgewater, and Roxbury Townships), Tolland County (except Willington, Coventry, Mansfield, and Columbia Townships), and Southbury, Middlebury, Waterbury, Wolcott, Naugatuck, Beacon Falls, Prospect, Cheshire, Wallingford, and Meriden Townships in New Haven County.
- 02- Southwest - New Milford, Washington, Bridgewater, and Roxbury Townships in Litchfield County and Fairfield County (except Monroe, Shelton, Trumbull, Easton, Fairfield, Bridgeport, and Stratford).
- 03 - South Central - Oxford, Seymour, Darby, Orange, Ansonia, Bethany, Woodbridge, Hamden, North Haven, New Haven, North Branford, Guilford, Madison, Branford, East Haven, West Haven, and Milford Townships in New Haven County and Monroe, Shelton, Trumbull, Easton, Fairfield, Bridgeport, and Stratford Townships in Fairfield County.
- 04 - Northeast and Southeast - Middlesex County, New London County (except the City of New London), Windham County, and Willington, Coventry, Mansfield, and Columbia Townships in Tolland County.

GEORGIA

Four Localities (by counties):

01	Fulton, Clayton, Dekalb, Butts, Cherokee, Cobb, Douglas, Fayette, Forsyth, Gwinnett, Henry, Newton, Paulding, Rockdale, Walton			
02	Chatham, Houston, Bibb, Richmond, Muscogee			
03	Whitfield, Floyd Troup, Coweta, Hall, Spalding, Clarke, Baldwin, Laurens, Bulloch, Ware, Glynn, Lowndes, Dougherty, Catoosa, Thomas, Walker			
04	Lumpkin Union Towns White Babun Banks Oconee Oglethorne Lincoln Taliaferro Jasper Putnam Hancock Glascock Warren Chattooga Gordon Murray Bartow Fannin Tallnall Appling Decatur Early Mitchell Wilkinson Twiggs Johnson Jeff Davis Charlton Turner	Habersham Stephens Franklin Hart Jackson Madison Elbert Barrow Dodge Randolph Terrell Crisp Sumter Dooly Macon Peach Harris Merriwether Lamar Monroe Liberty Wayne Colquitt Cook Berrien Jenkins Troup Candler Bacon Brantley Loe	Upson Chattahoochee Polk Haralson Carroll Seminole Miller Baker Atkinson Lanier Clinch Echols Calhoun Clay Quitman Stewart Webster Schley Marion Taylor Long Brooks Worth Tift Coffee Bleckley Palaski Wheeler McIntosh Pierce Wilcox	Talbot Crawford Pike Heard Pikens Gilmer Dade Dawson Newton Morgan Greene Wilkes McDuffie Columbia Washington Jefferson Burke Emanuel Screvin Ettingham Toombs Grady Ben Hill Tel Fair Jones Montgomery Evans Bryan Camden Irwin

ILLINOIS

Sixteen Localities:

Blue Cross/Blue Shield - Illinois Medical Service

Cook County

Continental Casualty - Illinois

- 01- Jo Daviess, Stephenson, Carroll, Ogle Counties
- 02- Winnebago, Mellenry
- 03- Whiteside, Lee, DeKalb, Kendall, LaSalle, Bureau, Grundy, Putnam Counties
- 04- Rock Island, Henry, Stark, Knox, Mercer, Warren & Henderson Counties
- 05- Peoria, Woodford & Marshall Counties
- 06- Kankakee, Iroquois, Ford & Livingston Counties
- 07- Hancock, McDonough, Schuyler, Brown, Cass, Morgan, Greene, Pike, Adams & Scott Counties
- 08- McLean, DeWitt, Logan, Tazewell, Mason & Fulton Counties
- 09- Menard, Sangamon & Christian Counties
- 10- Vermillion, Champaigne & Piatt Counties
- 11- Edgar, Douglas, Moultrie, Macon, Shelby, Cumberland, Coles & Clark Counties
- 12- Calhoun, Jersey, Macoupin, Montgomery, Bond, Madison, Clinton, Washington, St. Clair, Randolph & Monroe Counties
- 13- Crawford, Jasper, Effingham, Fayette, Marion, Clay, Richland, Lawrence, Wabash, Wayne, White, Hamilton, Jefferson, Edwards Counties
- 14- Gallatin, Saline, Franklin, Perry, Jackson, Williamson, Hardin, Pope, Johnson, Union, Alexander, Pulaski, Massac Counties
- 15- Lake, Kane, DuPage & Will Counties

INDIANA

Three Localities:

- 01 - Metropolitan-
Lake, Porter, LaPorte (Northwest Indiana)
Allen (Ft. Wayne)
Marion (Indianapolis), Shelby
Madison, Delaware (Anderson, Muncie)
Vanderburgh (Evansville)
- 02 - Urban-
Monroe, Grant, Tippecanoe, St. Joseph (South Bend), Clark,
Wayne, Wells, Floyd, Vigo (Terre Haute), Elkhart, Howard,
Cass, Henry, Lawrence, Kosciusko, Bartholomew, Hancock,
Hendricks, Johnson, Knox, LaGrange, Daviess
- 03 - Rural- Remaining Counties

MASSACHUSETTS

Two Localities: 01 Urban, 02 Suburban/Rural

AREA 01 - Urban - includes the following places

BOSTON SMSA
(Suffolk County)

Dorchester

Lynn

Peabody

Salem

Danvers

Hamilton

Lynnfield

Manchester

Marblehead

Middleton

Malden

Saugus

Swampscott

Topsfield

Wenham

(Middlesex County)
Cambridge

Everett

Halden

Medford

Melrose

Newton

Somerville

Waltham

Woburn

Arlington

Ashland

Bedford

Belmont

Burlington

Concord

Framingham

Lexington

Lincoln

Malden

North Reading

Reading

Shertown

Stoneham

Sudbury

Wakefield

Watertown

Weyland

Weston

Wilmington

Winchester

(Norfolk County)
Quincy

Braintree

Brookline

Canton

Cohasset

Dedham

Dorchester

Hoboken

Medfield

Mills

Milton

Needham

Norfolk

Norwood

Randolph

Sharon

Walpole

Wellesley

Westwood

Weymouth

(Plymouth County)
Duxbury

Hanover

Hingham

Hull

Marshfield

Norwell

Pembroke

Rockland

Scituate

Boston SMSA (cont.)

(Suffolk County)

Boston

Chelsea

Revere

Winthrop

BROCKTON SMSA
(Worcester County)

Easton

(Norfolk County)
Avon

Stoughton

(Plymouth County)
Brockton

Abington

Bridgewater

East Bridgewater

Hanson

West Bridgewater

Milton

WORCESTER SMSA
(Worcester County)

Auburn

Berlin

Boylston

Brookfield

East Brookfield

Grafton

Holden

Leicester

Millsbury

Northborough

Northbridge

North Brookfield

Oxford

Paxton

Shrewsbury

Spencer

Sterling

Sutton

Upton

Westborough

SPRINGFIELD-CHICOPEE-
HOVER, MASS.-CONN.-
SMSAMass. portion
(Hampden County)

Chicopee

Holyoke

Springfield

Westfield

Agawam

East Longmeadow

Hampden

Longmeadow

Ludlow

Hanson

Palmer

Southwick

West Springfield

Willsbraham

(Hampshire County)

Northampton

Easthampton

Granby

Hadley

South Hadley

(Worcester County)

Warren

PITTSFIELD SMSA

(Berkshire County)

Pittsfield

Dalton

Lenoxborough

Lee

Lenox

MASSACHUSETTS (Cont'd)

AREA 02 - Suburban/Rural - includes the following places in

SHSA's and the remainder of the State.

<u>FALL RIVER, MASS., R.I.</u> <u>SHSA</u>	Westford	(Hortfolk County)
Mass. portion (Bristol County)	<u>New Bedford, Mass.</u> <u>SHSA</u>	Dorlingham
Fall River	(Bristol County)	Franklin
Somerset	New Bedford	Plainville
Swansea	Acushnet	Wrentham
Westport	Dorimouth	(Worcester County)
<u>LAWRENCE-HAVERHILL, MASS.</u> <u>N.H. SHSA</u>	Fairhaven	Blackstone
Mass. portion (Essex County)	(Plymouth County)	Millville
Lawrence	Marion	
Haverhill	Mattapoisett	
Andover	<u>FITCHBURG-LEOMINSTER SHSA</u>	
Georgetown	(Middlesex County)	
Groveland	Shirley	
Herrinse	Townsend	
Hathuen	(Worcester County)	
North Andover	Fitchburg	
West Newbury	Leominster	
<u>LOWELL, MASS. SHSA</u>	Lunenburg	
(Middlesex County)	Westminster	
Lowell	<u>PROVIDENCE-PARTNERSHIP-</u> <u>HARRINGTON, R.I.</u> <u>SHSA</u>	
Billerica	Mass. portion (Bristol County)	
Chelmsford	Attleboro	
Dracut	North Attleborough	
Townsbury	Rehoboth	
Tyngsborough	Seekonk	

Two Localities:

01- Rural - All ZIP Codes starting with 386, 387, 388, 389, 390, 391, 393, 394, 396, 397 (except 38801, 39301, 39401) and the

following 395 ZIP Codes:

39550-Bond 39561-McHenry

39552-Escatawpa 39572-Pearlington

39553-Gautier 39573-Perkinston

39555-Hurley 39574-Saucier

39556-Kiln 39575-Wade

39558-Lakeshore 39577-Wiggins

02- Metropolitan - All ZIP Codes starting with 392 and 395 (except as noted in area 01 above) and the following:

392__ Jackson

395__ Biloxi

38801 Tupelo

39301 Meridian

39401 Hattiesburg

MISSOURI

Seven Localities:

General American Life

- 01 - Cities of Columbia, Jefferson City, Springfield, Metropolitan St. Louis, St. Louis County and St. Charles County
- 02 - Cities of Joplin, Cape Girardeau, Kirksville, Poplar Bluff, Hannibal, Sikeston and Jefferson County (City limits boundaries except Jefferson County)
- 03 - Rural - rest of State except Blue Shield of Kansas City area

Blue Shield of Kansas City - Missouri

- I - Buchanan County (rural)
- II - Clay and Platte Counties (suburban)
- III - Jackson County (metropolitan)
- VI - Rural - Andres, Atchison, Bates, Benton, Caldwell, Carroll, Cass, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Ray, St. Clair, Saline, Vernon, Worth

NEW YORK

Ten Localities:

New York B/S of Greater New York

- A - New York County
- B - Bronx, Kings, Richmond, Westchester, Nassau, Rockland, and Suffolk Counties
- C - Dutchess, Orange, Putnam, Sullivan, Ulster, Columbia, Delaware, and Green Counties

Group Health Insurance - New York

Queens County

Blue Shield of Western New York

Alleghany, Cattaraugus, Erie, Genesee, Niagara, Orleans
and Wyoming Counties

Genesee Valley Medical Care Inc. - New York

Livingston, Monroe, Ontario, Seneca, Wayne and Yates
Counties

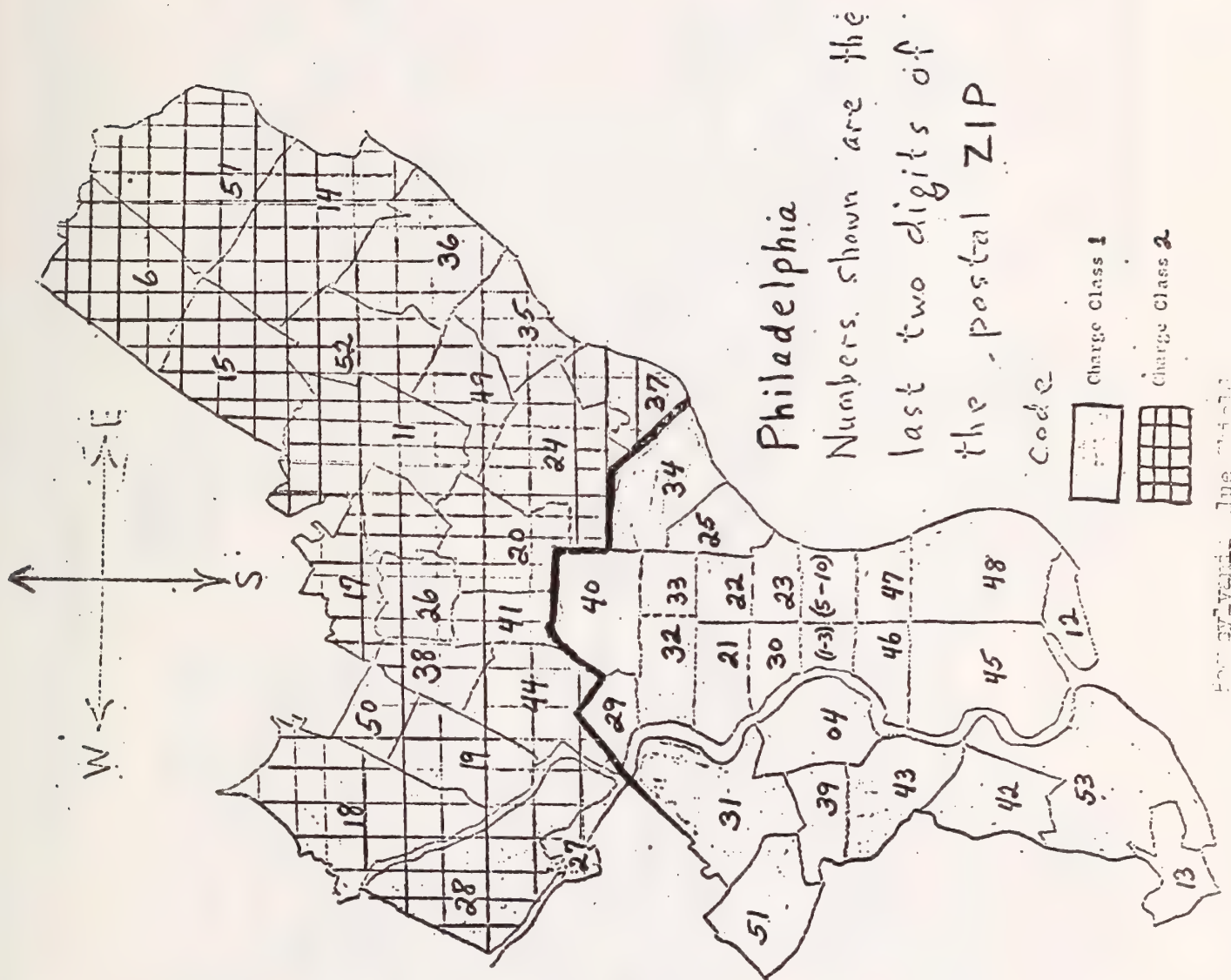
Metropolitan Life Insurance Company - New York

Geographic Area I - Includes the following cities:

Albany	Saratoga Springs	Cooperstown
Binghamton	Schenectady	Marcellus
Endicott	Syracuse	Fayetteville
Glens Falls	Utica	New Hartford
Johnson City	Troy	Ogdensburg
(The city limits are the locality boundaries.)		

Geographic Area II - All towns and communities in the
following counties other than the nine cities shown
in Area I:

Albany	Fulton	Rensselaer
Broome	Hamilton	Saratoga
Cayuga	Herkimer	Schenectady
Chautauqua	Jefferson	Schoharie
Chemung	Lewis	Schuyler
Chenango	Madison	St. Lawrence
Clinton	Montgomery	Steuben
Cortland	Oneida	Tioga
Essex	Onondaga	Tompkins
Franklin	Oswego	Warren
	Otsego	Washington



Foray, Inc. 1980



Pittsburgh
 Numbers shown are the
 last two digits of the
 postal ZIP code

Pennsylvania Blue Shield

Texas

Thirty-two Localities:

Counties --(Cities)

- 014 - Bell (Killeen-Ft.Hood)
- 015 - Bexar (San Antonio)
- 019 - Bowie (Texarkana)
- 020 - Brazoria (Freeport)
- 031 - Cameron (Brownsville)
- 057 - Dallas (Dallas)
- 061 - Denton (Denton)
- 068 - Ector (Odessa)
- 071 - El Paso (El Paso)
- 084 - Galveston (Galveston)
- 091 - Grayson (Sherman)
- 092 - Gregg (Longview)
- 101 - Harris (Houston)
- 108 - Hidalgo (Pharr-McAllen)
- 123 - Jefferson (Beaumont)
- 152 - Lubbock (Lubbock)
- 155 - McLennan (Waco)
- 165 - Midland (Midland)
- 178 - Nueces (Corpus Christi)
- 181 - Orange (Orange)
- 181 - Potter (Amarillo)

- 212 - Smith (Tyler)
- 220 - Tarrant (Fort Worth)
- 221 - Taylor (Abilene)
- 226 - Tom Green (San Angelo)
- 227 - Travis (Austin)
- 235 - Victoria (Victoria)
- 240 - Webb (Laredo)
- 243 - Wichita (Wichita Falls)
- 750 - North Central, North East Texas
- 770 - Central, South, Southeast Texas
- 790 - Panhandle and West Texas

(The localities are determined on a County basis. The cities listed are major cities in the locality.)

(Area 260 is the Statewide locality for certain specialties.)

- 750 - Morris, Montague, Cooke, Fannin, Lamar, Red River, Collin, Hunt, Delta, Titus, Camp, Cass, Trinity, Marion, Harrison, Panola, Rusk, Wood, Hopkins, Rains, Kaufman, Van Zandt, Parker, Ellis, Johnson, Hood, Jack, Rockwall, Coryelle, Comanche, Wise, Somervell, Erath, Hill, Bosque, Hamilton, Freestone, Limestone, Anderson, Navarro, Leon, Upshur, Houston, Madison, Franklin, Cherokee, Falls, and Young Counties.
- 770 - Shelby, Sabine, Angelini, Newton, Jasper, Tyler, Polk, Macgdoches, San Augustine, Walker, San Jacinto, Hardin, Chambers, Grimes, Montgomery, Robertson, Brazos, Burleson, Washington, Lee, Williamson, Mills, Lampasas, Burnet, Henderson, Aransas, San Saba, Austin, Colorado, Wharton, Gillespie, Blanco, Kendall, Kerr, Real, Hays, Caldwell, Fayette, Matagorda, Calhoun, Refugio, Lavaca, Gonzales, San Patricio, Kleberg, Waller, Kennedy, Willacy, Jim Wells, Duval, Brooks, Zapata, Starr, Jim Hogg, La Salle, Dimmitt, McMullen, Live Oak, Bee, Karnes, Wilson, Atascosca, Frio, Zavala, Uvalde, Medina, Comal, Fort Bend, De Witt, Goliad, Bandera, Guadalupe, Jackson, Liberty, Milam, Llano, Bastrop Counties.
- 790 - Dallam, Sherman, Hansford, Ochiltree, Hartley, Moore, Hutchinson, Hemphill, Carson, Gray, Wheeler, Deaf Smith, Pandal, Armstrongs, Donley, Parmer, Castro, Swisher, Briccoe, Hall, Childress, Shackelford, Bailey, Lamb, Hale, Floyd, Motley, Cottle, Foard, Wilbarger, Clay, Archer, Baylor, Knox, Dickens, Crosby, Hockley, Cochran, Yoakum, Terry, Lynn, Garza, Kent, Stonewall, Haskell, Gaines, Dawson, Borden, Schurry, Fisher, Jones, King, Winkler, Ward, Upton, Throckmorton, Runnels, Collingsworth, Brewster, Hardeman, Irion, Lipscomb, Menard, Olcham, Stephens, Palo Pinto, Andrews, Martin, Howard, Mitchell, Nolan, Callahan, Eastland, Hudspeth, Culberson, Reeves, Loving, Glasscock, Sterling, Coke, Coleman, Brown, Crane, Roberts, Regan, Concho, McCulloch, Sutton, Mason, Schleicher, Crockett, Pecos, Jeff Davis, Presidio, Terrell, Val Verde, Kimble, Edwards, Kinney, and Maverick Counties.

WISCONSIN

Eleven Localities:

Surgical Care - Blue Shield Wisconsin

Milwaukee - 04

Wisconsin Physicians ServiceBlue Shield (Counties)

B
Ashland
Barron
Bayfield
Burnett
Chippewa
Clark
Douglas
Iron
Polk
Price
Rusk
Sawyer
Taylor
Washburn

D
Crawford
Grant
Iowa
Lafayette
Richland
Sauk
Vernon

C
Adams
Columbia
Green Lake
Juneau
Marquette
Monroe
Waushara

E
Buffalo
Dunn
Eau Claire
LaCrosse
Pepin
Pierce
St. Croix
Trempealeau
Jackson

F
Langlade
Lincoln
Marathon
Oneida
Portage
Vilas
Wood

H
Kenosha
Ozaukee
Racine
Washington
Waukesha

J
Calumet
Fond du Lac
Manitowish
Sheboygan
Winnebago

G
Brown
Door
Florence
Forest
Kewaunee
Marinette
Oconto
Outagamie
Shawano
Waupaca

I
Dodge
Green
Jefferson
Rock
Walworth

K
Dane

[illegible]

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prevailing charges.

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Medicare directory of
prevailing charges.

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